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PLANNING AND EVALUATION

OFFICE OF
HEALTH POLICY

CONTRACTOR PROJECT REPORT

Developing Health Equity Measures

Prepared for
**the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
at the U.S. Department of Health & Human Services**

by
RAND Health Care

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Office of the Assistant Secretary for Planning and Evaluation

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ASPE Project Team

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ASPE Executive Summary

In 2014, under the Improving Medicare Post-Acute Care (IMPACT) Act, Congress asked that ASPE study the relationship between social risk factors¹ and Medicare's value-based purchasing (VBP) programs. ASPE wrote two Reports to Congress, making recommendations based on the studies' findings. This included the recommendations that the Centers for Medicare and Medicaid Services (CMS) include measures of health equity in public reporting and VBP programs. Moreover, in the ASPE commissioned report, *Systems Practices for the Care of Socially At-Risk Populations*, the National Academies of Sciences, Engineering, and Medicine calls out a commitment to health equity as one of six promising practices to improve care for socially at-risk populations.²

However, as Medicare's VBP programs do not currently include health equity measures, appropriate measures need to be developed and/or identified before they can be incorporated into these programs. In response to this challenge, ASPE asked the RAND Corporation to develop a proposed definition of health equity as a starting place and to identify existing health equity measurement approaches that may be suitable for inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports. RAND identified 10 existing approaches to health equity measurement and convened a technical expert panel (TEP) to:

- (1) provide feedback on the project team's proposed definition of a health equity measure and identification of features of health equity measurement approaches;
- (2) develop a set of criteria for evaluating health equity measurement approaches for potential inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports; and
- (3) evaluate the set of health equity measurement approaches identified by the team according to these criteria.

Based on input from RAND, ASPE, and the TEP, in this report RAND defines a **health equity measurement approach** as *"an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients."* We note that this definition focuses on health care quality, as that was the charge from Congress under the IMPACT Act, but measurement approaches could be considered more broadly in other contexts.

The purpose of including health equity measurement approaches in VBP programs and quality reporting efforts is to motivate a focus on improving health for all by reducing disparities and to help providers prioritize particular areas for quality improvement. It could also encourage providers to improve health equity through service enhancements, patient engagement activities, and adoption of best practices.

Of the 10 health equity measurement approaches evaluated by the TEP (which are described in detail in the report itself), the CMS Office of Minority Health's (OMH) Health Equity Summary Score (HESS) received the highest ratings from the TEP overall. This approach first identified those patient

¹ The term "social risk factors" was suggested by the National Academies of Sciences, Engineering, and Medicine as discussed below.

² National Academies of Sciences, Engineering, and Medicine. 2016. *Systems practices for the care of socially at-risk populations*. Washington, DC: The National Academies Press.

experience and clinical care measures that are most suitable for health equity comparisons. Then, the HESS assessed the extent to which care provided through Medicare Advantage contracts was equitable based on race, ethnicity, and dual/low-income subsidy (LIS) eligibility status. The HESS combines data across multiple performance measures, multiple social risk factors, and multiple types of comparisons to create a summary index of health equity.

The Biden-Harris Administration has emphasized the importance of equity across the government, and health equity in particular. This report directly responds to Executive Order 13985, *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, which asks all federal agencies to “identify the best methods, consistent with applicable law, to assist agencies in assessing equity with respect to race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability.”³ Although this report focuses on the Medicare program, much of the findings are applicable more broadly, including the definition of a health equity measurement approach, the criteria that were developed for evaluating health equity measures, and the TEP’s discussion of the measures identified.

Going forward, the health equity measures identified and evaluated in this report can contribute to HHS implementation of Executive Order 13985 and the recommendations in the Report to Congress on the Role of Social Risk in Medicare’s Value-Based Purchasing Programs.⁴

A Note on Social Risk Factors, Race, and Ethnicity

Although the IMPACT Act required that ASPE study “the effect of individuals’ socioeconomic status on quality measures,” ASPE commissioned a series of reports from the National Academies of Science, Engineering, and Medicine who suggested that the term “social risk factors” was more appropriate and provided a conceptual model that listed the specific domains and risk factors.⁵ ASPE’s Reports to Congress and follow-on work, including this report, have used the term social risk factors and the specific factors identified.⁴ In more recent years, there has been further discussion on appropriate terminology, including understanding the distinctions between social determinants of health, social risk factors, and social needs.^{6,7} This continuing discussion shows the interconnectedness of these concepts, while also recognizing that not all characteristics and needs can or should be addressed in the same way.

The social risk factors identified by the National Academies of Science, Engineering, and Medicine include the domains of socioeconomic position; race, ethnicity, and cultural context; gender; social relationships; and residential and community context. These domains and the individual factors within them were identified based on existing evidence of the association between the factor and worse health outcomes. We note that the factors identified include both modifiable social determinants of health, and also additional, non-modifiable factors such as race and ethnicity, which

³ See <https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government>

⁴ See all of ASPE’s work on this topic at <https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs>

⁵ National Academies of Sciences, Engineering, and Medicine. 2016. *Accounting for social risk factors in Medicare payment: Identifying social risk factors*. Washington, DC: The National Academies Press.

⁶ Alderwick, H. and Gottlieb, L.M., 2019. Meanings and misunderstandings: a social determinants of health lexicon for health care systems. *The Milbank Quarterly*, 97(2), p.407.

⁷ Green, K. and Zook M., 2019. When Talking About Social Determinants, Precision Matters. *Health Affairs Blog*, October 29. Available at <https://www.healthaffairs.org/doi/10.1377/hblog20191025.776011/full/>.

are themselves not causal factors for disparities but are subject to structural inequities that produce adverse health outcomes.

The Biden-Harris Administration's emphasis on health equity brings an additional perspective to this issue. In addressing health equity, we in the federal government include many of the same factors that the National Academies of Science, Engineering, and Medicine identified as social risk factors. We take a slightly different perspective than presented by National Academies of Science, Engineering, and Medicine and consider non-modifiable factors such as race, ethnicity, and rural location as associated with health disparities, but not risk factors themselves or drivers of those disparities. We are interested in identifying non-modifiable factors, such as race and ethnicity, to assess differential health outcomes. We also focus on modifiable factors, such as structural racism, that are the drivers of the outcome differences. Addressing health equity issues requires implementing interventions to address the drivers of outcome differences and monitoring outcomes to determine whether equity improved. Such monitoring is built on the health equity measurement approaches evaluated in this report.

Developing Health Equity Measures

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Preface

Socially at-risk individuals receive lower-quality health care and experience worse health outcomes than more advantaged individuals. One way to address this in the Medicare population is to use Medicare's value-based purchasing (VBP) programs, quality reporting efforts, and confidential reports as tools to drive improvements in quality. In particular, including health equity measurement approaches in VBP programs and quality reporting could motivate providers to focus on reducing disparities and to prioritize particular areas for quality improvement. It could also encourage providers to improve health equity through service enhancements, patient engagement activities, and adoption of best practices.

In this project, RAND Corporation researchers identified existing health equity measurement approaches that might fit with Medicare's VBP programs, quality reporting efforts, and confidential reports. The project had two objectives: (1) identify health equity measurement approaches, and (2) decide which of these approaches merit consideration for inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports. This report describes the methods and findings of the project and delineates potential first steps for the U.S. Department of Health and Human Services to consider as it continues to evaluate the prospect of incorporating health equity measures and domains in Medicare's VBP and reporting programs.

This research was funded by the Office of the Assistant Secretary for Evaluation and Planning in the U.S. Department of Health and Human Services and carried out within the Quality Measurement and Improvement Program in RAND Health Care.

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Contents

Preface.....	Error! Bookmark not defined.ii
Contents.....	ix
Figures.....	xi
Tables	xii
Abbreviations	xiii
Summary	xiv
1. Background and Purpose	1
<i>Background</i>	1
<i>Project Objectives</i>	2
2. Literature Review Methods and Results	4
Definition of a Health Equity Measurement Approach to Assess Organizational Contributions	4
Search Strategy	4
<i>Eligibility Criteria</i>	5
<i>Article/Report Screening</i>	5
3. Detailed Information on Identified Approaches	12
Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards (HHS OMH).....	12
NQF Disparities-Sensitive Measure Assessment.....	14
AHRQ <i>National Healthcare Quality and Disparities Report</i>	16
CMS OMH Mapping Medicare Disparities Tool.....	18
CMS OMH Reporting of CAHPS and HEDIS Data Stratified by Race and Ethnicity for Medicare Beneficiaries.....	19
<i>Minnesota Healthcare Disparities Report</i>	20
CMS Assessment of Hospital Disparities for Dual-Eligible Patients.....	22
CMS OMH Health Equity Summary Score	23
Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity.....	26
Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity.....	27
4. Summary of Identified Health Equity Measurement Approaches.....	28
5. Technical Expert Panel Process and Members.....	32

6. TEP Input on Project Framing and Approach	33
Input on Definition of a Health Equity Measurement Approach	33
Input on Premise of the Project	34
Input on Evaluation Criteria	34
7. Detailed Assessment of Identified Approaches	37
Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards	37
NQF Disparities-Sensitive Measure Assessment	40
<i>AHRQ National Healthcare Quality and Disparities Report</i>	42
CMS OMH Mapping Medicare Disparities Tool	44
CMS OMH Reporting of CAHPS and HEDIS Data, Stratified by Race and Ethnicity, for Medicare Beneficiaries	46
<i>Minnesota Healthcare Disparities Report</i>	48
CMS Assessment of Hospital Disparities for Dual-Eligible Patients	50
CMS OMH Health Equity Summary Score	52
Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity	54
Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity	56
8. Summary and Key Takeaways	58
<i>Summary</i>	58
<i>Key Takeaways</i>	59
Appendix A. Ambulatory, Hospital, Behavioral Health, and Public Health Measures Identified as Part of the Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards (HHS OMH)	61
Appendix B. Measures Identified as Disparities-Sensitive According to the NQF Disparities- Sensitive Measure Assessment	63
Appendix C. Biographical Information on Expert Panelists	66

Figures

Figure 2.1. Literature Review Flow Diagram.....	10
Figure 3.1. NQF Disparities-Sensitive Measure Identification.....	15
Figure 4.2. Components of the HESS	25
Figure 4.3. HESS: Blending Scheme.....	25

Tables

Table S.1. Ten Identified Approaches to Health Equity Measurement.....	xix
Table 2.1. Database Search Strategy.....	7
Table 2.2. Summary of the Health Equity Measurement Approaches Identified by the Literature Review	11
Table 3.1. Cross-Cutting Measures to Evaluate How Well an Organization Meets National CLAS Standards.....	13
Table 4.1. Summary of Identified Approaches to Health Equity Measurement	31
Table 7.1. TEP Ratings of Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards.....	39
Table 7.2. TEP Ratings of NQF Disparities-Sensitive Measure Assessment.....	41
Table 7.3. TEP Ratings of <i>AHRQ National Healthcare Quality and Disparities Report</i>	43
Table 7.4. TEP Ratings of CMS OMH Mapping Medicare Disparities Tool	45
Table 7.5. TEP Ratings of CMS OMH Reporting of CAHPS and HEDIS Data Stratified by Race and Ethnicity for Medicare Beneficiaries.....	47
Table 7.6. TEP Ratings of Minnesota Healthcare Disparities Report.....	49
Table 7.7. TEP Ratings of CMS Assessment of Hospital Disparities for Dual-Eligible Patients.....	51
Table 7.8. TEP Ratings of CMS OMH Health Equity Summary Score.....	53
Table 7.9. TEP Ratings of Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity	55
Table 7.10. TEP Ratings of Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity	57

Abbreviations

AAC	average annual change
AHRQ	Agency for Healthcare Research and Quality
ASPE	Assistant Secretary for Planning and Evaluation
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
HEDIS	Healthcare Effectiveness Data and Information Set
HESS	Health Equity Summary Score
HHS	U.S. Department of Health and Human Services
LIS	Low-Income Subsidy
MA	Medicare Advantage
MeSH	Medical Subject Headings
MMD	Mapping Medicare Disparities
NQF	National Quality Forum
OMH	Office of Minority Health
PDP	prescription drug plan
RSRR	risk-standardized readmission rate
TEP	technical expert panel
VBP	value-based purchasing

Summary

There is growing recognition that social risk factors⁸—such as income, education, race and ethnicity, and community resources—play a major role in health.⁹ Despite ongoing efforts to address inequities, evidence suggests that socially at-risk individuals receive lower-quality health care and experience worse health outcomes than more-advantaged individuals. Medicare’s value-based purchasing (VBP) programs, quality reporting efforts, and confidential reports to providers of their performance on quality measures could be powerful tools to drive improvements in the quality of care provided to socially at-risk individuals. In particular, including health equity measurement approaches in VBP programs and quality reporting efforts could motivate a focus on reducing disparities and help providers prioritize particular areas for quality improvement. It could also encourage providers to improve health equity through service enhancements, patient engagement activities, and adoption of best practices.

Toward that end, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked the RAND Corporation to identify existing health equity measurement approaches that may be suitable for inclusion in Medicare’s VBP programs, quality reporting efforts, and confidential reports. This project had two objectives: (1) identify health equity measurement approaches, and (2) decide which of these approaches merit consideration for inclusion in Medicare’s VBP programs, quality reporting efforts, and confidential reports. To meet these objectives, the project team conducted a literature review to identify health equity measurement approaches developed or used for the purpose of systematic performance assessment and convened a technical expert panel (TEP) to consider the use of these health equity measurement approaches in VBP programs, quality reporting efforts, and confidential reports. The project team synthesized feedback from the TEP to identify the most promising health equity measurement approaches and inform the U.S. Department of Health and Human Services (HHS) about which approaches could be incorporated in Medicare’s VBP programs, quality reporting efforts, and confidential reports.

A formal **definition of a health equity measurement approach** was developed to define the scope of the literature search and help specify the TEP’s evaluation of the identified approaches. The definition, which was first developed iteratively by RAND and ASPE and then further shaped by the TEP, is as follows: an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in

⁸ Though many people use the term *social risk factor* to refer to mechanisms that foster inequities in health or health care—e.g., food insecurity or language barriers—we use the term here to refer to groups that tend to bear a disproportionate share of social risk factor burden, e.g., racial and ethnic minorities. In that sense, we are conceptualizing group membership as a proxy for social risk factors. By using the term *social risk factor* to refer to membership in certain groups, we do not mean to imply that risk or disadvantage is inherent in people, homogeneous within groupings (e.g., a particular race) or across geography, or immutable over time. Rather, it is the result of past and present inequities in our society.

⁹ National Academies of Science, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*, Washington, D.C.: National Academies Press, 2016; United States Department of Health and Human Services, “Healthy People 2020: Social Determinants of Health,” webpage, 2014. As of May 11, 2020: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients.

Ten such approaches were identified. These ten approaches fit within **three broad categories of approaches**: (1) approaches focused on determining which existing quality measures are suitable for health equity comparisons (i.e., permit reliable and valid comparisons among social risk factor groups) or for measuring organizational structures, systems, and processes hypothesized to promote the delivery of high-quality care for all; (2) approaches that engaged in particular kinds of comparisons of measures (not necessarily statistical comparisons), on a measure-by-measure basis, between groups of patients with greater versus lesser social risk factor burden; and (3) approaches that developed a system for combining different dimensions of health equity into a single summary index. Table S.1 lists these ten approaches and provides summary information about them, including whether the approach focused on measure identification (Category 1), measure-by-measure comparisons (Category 2), or creating a summary index (Category 3).

This project also identified a set of guidelines for health equity measurement. A health equity measurement approach should, ideally,

- be based on measures on which disparities in care are known to exist for certain populations or that address health care disparities and culturally appropriate care
- reflect available evidence on the relationship between a social risk factor and health or health care outcome
- be designed to incentivize achievement or improvement for at-risk beneficiaries, including having a valid and appropriate benchmark and/or reference group if comparisons to benchmarks and/or reference groups are made
- include design features that guard against unintended consequences of worsening quality or access or disincentivizing resources for any beneficiaries, including the at-risk beneficiaries who are the focus of health equity measurement
- establish measurability requirements that ensure the ability to make reliable distinctions between health care providers in their performance in the domain of health equity
- capture information about small subgroups where possible while limiting the influence of imprecise estimates of provider performance.

In the case of a summary index, the measure should additionally

- summarize information in a way that is psychometrically sound
- allow for disaggregation of information to permit easy identification of quality improvement targets.

Two of the identified approaches—the Measurement Framework for Evaluating Organizational Compliance with Standards for National Culturally and Linguistically Appropriate Services (CLAS) and the National Quality Forum’s (NQF) Disparities-Sensitive Measure Assessment—determined whether existing quality measures were suitable for health equity comparisons or for measuring organizational structures, systems, and processes hypothesized to promote delivery of high-quality care for all (Category 1).

Two approaches—the Agency for Healthcare Research and Quality’s (AHRQ) National Healthcare Quality and Disparities Report and the Mapping Medicare Disparities (MMD) Tool developed by the Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH)—focused on performance comparisons by social risk-factor groups either nationally or at a smaller geographical unit. Each of these two approaches included a broad array of measures,

treating each measure separately (the hallmark of Category 2), though only the AHRQ approach involved statistical comparisons.

Two approaches—the CMS OMH stratified reporting of Medicare Advantage (MA), prescription drug plan (PDP), and Medicare Fee-for-Service (FFS) performance data by beneficiary race and ethnicity and the Minnesota Healthcare Disparities Report—involved stratified reporting of data on patient experience and/or clinical care by social risk factors with statistical comparisons to benchmarks. The CMS Office of Minority Health’s approach involved reporting performance at the level of MA contracts, PDP contracts, and states (for Medicare FFS), and the Minnesota Healthcare Disparities Report involved reporting performance both statewide and at the level of individual medical groups. Under these approaches, comparison of performance by contract, state, or medical group was done on a measure-by-measure basis (Category 2).

The CMS Assessment of Hospital Disparities for Dual-Eligible Patients involved two complementary methods for assessing hospital performance in the realm of health equity. The Within-Hospital Disparity Method was used to measure the difference in a health outcome between patients who are dually eligible for Medicare and Medicaid (referred to as dual-eligible patients)¹⁰ and patients who are not dually eligible within a hospital. The Dual Eligible Outcome Method was used to compare performance for dual-eligible patients across hospitals. In each case, the outcome measure of interest was 30-day all-cause unplanned readmission following hospitalization for pneumonia. Because this approach involved only one social risk factor and one outcome measure and the two types of comparisons were kept separate, it fits within Category 2.

Two approaches were identified within Category 3. The CMS OMH’s Health Equity Summary Score (HESS) approach identified patient experience and clinical care measures specifically suitable for health equity comparisons and used data on those measures to assess the extent to which care provided through MA contracts was equitable based on race and ethnicity as well as dual/low-income subsidy (LIS) eligibility status. The HESS combined data across multiple performance measures, multiple social risk factors, and multiple types of comparisons, i.e., both within- and between-provider comparisons and comparisons focused on both cross-sectional performance and improvement in performance to create a summary index of health equity (Category 3).

Zimmerman’s Health-Related Quality of Life Approach to Measuring Health Equity synthesized information across multiple measures (Category 3). Zimmerman’s measure is oriented toward assessing the total deviation from a defined privileged group and allows disaggregation from the national level to the level of states and smaller geographic areas. Zimmerman and Anderson developed a related approach that generates trend information to characterize disparities in self-rated health and healthy days in the past month as either decreasing, increasing, or not changing (this approach involved both Category 2 and Category 3 assessments).

Of approaches focused on measure identification (Category 1), the **NQF Disparities-Sensitive Measure Assessment** was viewed most favorably by the TEP. Using a set of carefully established criteria and an easy-to-understand point system, this approach identified 76

¹⁰ The demonstration of this approach focused on full dual-eligible beneficiaries aged 65 and older.

existing NQF-endorsed measures as disparities-sensitive.¹¹ Although considerable work would be needed to determine whether and how these measures could be linked to social risk data and whether and how valid comparisons could be made, this approach was viewed as a valuable initial step toward measuring health equity and disparities in health care quality. It is potentially applicable to any Medicare VBP or quality reporting program that collects one or more of the disparities-sensitive measures.

Of approaches focused on measure-by-measure comparisons (Category 2), **the approach underlying the Minnesota Healthcare Disparities Report** was judged most favorably by the TEP. The perceived advantages of this approach include its thoughtfully chosen group of measures, incorporation of multiple important social risk factors (i.e., race, ethnicity, preferred language, and country of origin), ability to reliably distinguish performance among providers, clear focus on incentivizing achievement for at-risk beneficiaries, and choice to anchor disparities to the overall state average rather than the performance of a predetermined group. Although some additional work would be needed to transfer this approach to a broader setting, including making careful considerations about sample sizes required for accurate comparisons and determining the availability of data on social risk factors, the method itself is readily applicable to all Medicare VBP and quality reporting programs.

Of approaches focused on summary indices (Category 3), the **CMS OMH HESS** was judged most favorably by the TEP. The perceived advantages of this approach include its joint consideration of cross-sectional performance and improvement in performance, focus on patient experience and clinical quality, careful attention to reliability and the sample size required to achieve it, direct applicability to certain VBP and quality reporting programs, and transferability to other programs. CMS is currently developing a dashboard to provide confidential HESS data to MA contracts in the near future. Scores on this metric could potentially be incorporated into the Medicare Plan Finder and the MA Quality Star Ratings Program. This approach could easily be extended to other social risk factors and measures, and there are plans to test the feasibility of extending this approach to settings beyond MA.

Of the ten approaches evaluated, the HESS received the highest ratings from the TEP overall. Given the high ratings it received, the HESS may be closest to meeting the full scope of goals outlined by ASPE for incorporating a measure of health equity into a Medicare VBP or quality reporting program. If HHS were to move forward with this approach, it could consider possible refinements to the approach based on the practices established by the NQF Disparities-Sensitive Measure Assessment and the Minnesota Healthcare Disparities Report and the guidelines for health equity measurement outlined by the TEP. Several of the measures that are included in the HESS are among the 76 measures identified as disparities-sensitive by NQF. It might be possible to include in the HESS additional measures from the set identified by NQF, provided that the measures are collected for MA plans and meet the reliability and sample size requirements established for the HESS. The analyses that underlie the Minnesota Disparities Report are similar to the analyses that underlie the cross-sectional component of the HESS. In the Minnesota Healthcare Disparities Report, plan performance by patients' preferred language and country of origin are considered in addition to race and ethnicity. Information on country of origin is not available for MA beneficiaries, but information about Spanish preference is

¹¹ *Disparities-sensitive measures* were defined as measures of conditions that are prevalent among at-risk groups, measures assessing a *high-impact* aspect of health care (i.e., conditions affecting large numbers of people, leading causes of morbidity and mortality, conditions leading to high resource use, and severe illnesses), measures on which a substantial disparity has been identified, and measures that map to an NQF-endorsed communication-sensitive practice for care coordination or cultural competency.

available. Thus, Spanish preference could be considered as a possible third social risk factor for the HESS.

Table S.1. Ten Identified Approaches to Health Equity Measurement

Measurement Approach	Setting/Population	Social Risk Factor(s)	Focus
1. Measurement Framework for Evaluating How Well an Organization Meets National Standards for Culturally and Linguistically Appropriate Services (HHS OMH)	Health care organizations	Race/ethnicity; limited English proficiency; low literacy	Measure identification
2. NQF Disparities-Sensitive Measure Assessment	Cross-cutting	Race/ethnicity	Measure identification
3. AHRQ National Healthcare Quality and Disparities Report	Overall U.S. population	Age; sex, race/ethnicity	Measure-by-measure comparisons
4. CMS OMH Mapping Medicare Disparities Tool	Medicare FFS	Race/ethnicity; dual eligibility; sex; age	Measure-by-measure comparisons
5. CMS OMH Reporting of CAHPS and HEDIS Data by Race/Ethnicity for Medicare Beneficiaries	MA and prescription drug plans, Medicare FFS	Race/ethnicity	Measure-by-measure comparisons
6. Minnesota Healthcare Disparities Report	Minnesota health plan enrollees	Race, ethnicity, preferred language, country of origin	Measure-by-measure comparisons
7. CMS Assessment of Hospital Disparities for Dual-Eligible Patients	Hospitals	Dual eligibility	Measure-by-measure comparisons
8. CMS OMH Health Equity Summary Score	Medicare Advantage plans	Race/ethnicity; dual eligibility	Summary index
9. Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity	General adult U.S. population	Race/ethnicity; sex; income	Summary index
10. Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity	General adult U.S. population	Race/ethnicity; sex; income	Measure-by-measure comparisons; summary index

NOTE: CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; HHS = U.S. Department of Health and Human Services; FFS = fee-for-service; HEDIS = Healthcare Effectiveness Data and Information Set; MA = Medicare Advantage; NQF = National Quality Forum; OMH = Office of Minority Health

1. Background and Purpose

Background

There is growing recognition that social risk factors¹²—such as income, education, race and ethnicity, and community resources—play a major role in health.¹³ Despite ongoing efforts to address inequities, evidence suggests that socially at-risk individuals receive lower-quality health care and experience worse health outcomes than more-advantaged individuals.¹⁴

Medicare's value-based purchasing (VBP) programs, which link reimbursement to the quality and efficiency of health care delivered, could be a powerful tool to drive improvements in the quality of care provided to patients with social risk factors, which could potentially improve health outcomes among patients with social risk factors and reduce health disparities. Medicare's VBP programs include pay-for-performance programs in each health care setting that reward providers on quality and cost, as well as Alternative Payment Models, such as Accountable Care Organizations, or state population-based models in which providers are at financial risk for lowering costs and improving quality of care. The scope of this report is focused mainly on pay-for-performance programs. Quality reporting efforts and confidential reports to providers may have similar incentivizing effects. The National Academy of Medicine identified the following social risk factors as likely to be important to health outcomes for Medicare beneficiaries: socioeconomic position; race, ethnicity, and cultural context; gender; social relationships; and residential and community context.¹⁵ Including health equity measurement approaches in VBP and quality reporting programs could motivate a focus on reducing disparities and help providers prioritize particular areas for quality improvement activities. It could also encourage providers to address health equity through service enhancements, patient engagement activities, and adoption of best practices to improve performance in the health equity domain. The use of health equity measurement approaches as

¹² Though many people use the term *social risk factor* to refer to mechanisms that foster inequities in health or health care—e.g., food insecurity or language barriers—we use the term here to refer to groups that tend to bear a disproportionate share of social risk factor burden, e.g., racial and ethnic minorities. In that sense, we are conceptualizing group membership as a proxy for social risk factors. By using the term social risk factor to refer to membership in certain groups, we do not mean to imply that risk or disadvantage is inherent in people, homogeneous within groupings (e.g., a particular race) or across geography, or immutable over time. Rather, it is the result of past and present inequities in our society.

¹³ National Academies of Science, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*, Washington, D.C.: The National Academies Press, 2016; U.S. Department of Health and Human Services (HHS), “Healthy People 2020: Social Determinants of Health,” webpage, 2014. As of May 11, 2020: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

¹⁴ Institute of Medicine, *How Far Have We Come in Reducing Health Disparities? Progress Since 2000: Workshop Summary*, Washington, D.C.: National Academies Press, 2012.

¹⁵ Assistant Secretary for Planning and Evaluation, *Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*, Washington, D.C.: HHS, 2016; National Academies of Science, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*, Washington, D.C.: National Academies Press, 2016.

part of VBP and quality reporting sends a strong signal that health equity is an important component of delivery system transformation.

However, if beneficiaries with social risk factors have worse outcomes because of elements beyond the control of health care providers, the inclusion of health equity measurement approaches in VBP and quality reporting programs could make providers reluctant to care for beneficiaries with social risk factors, out of fear of incurring penalties, not achieving bonuses, or having their reputations damaged due to factors they have limited ability to influence.

In 2014, under the Improving Medicare Post-Acute Care Act,¹⁶ Congress asked that the Assistant Secretary for Planning and Evaluation (ASPE) study the relationship between social risk factors and Medicare's VBP programs. ASPE wrote two Reports to Congress (referred to as *Study A* and *Study B*), making recommendations based on the study's findings. These reports outline multiple strategies for accounting for social risk factors in Medicare's VBP programs.¹⁷ Although the reports recommend including health equity measures in Medicare's VBP programs, they do so cautiously, outlining several considerations that need to be addressed first. For example, the reports stress that the design of any such measurement approach needs to be informed by careful consideration of the linkage between social risk factors and the outcome or outcomes measured. They also highlight the need to consider whether score adjustments are needed to account for factors outside the control of providers. Steps such as these ensure that health equity measurement approaches can be used in VBP programs to incentivize improvements for beneficiaries with social risk factors while guarding against any real or perceived disincentives to care for these beneficiaries.

Project Objectives

ASPE asked the RAND Corporation to identify existing health equity measurement approaches that may be suitable for inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports. This project had two objectives:

1. Identify and describe health equity measurement approaches.
2. Decide which of these merit consideration for inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports.

In August 2020, the project team conducted a literature review to identify health equity measurement approaches developed or used for the purpose of systematic performance assessment. In September 2020, the project team convened a technical expert panel (TEP) with experts on social risk factors, health disparities, health equity, quality measurement, and Medicare's VBP programs and quality reporting efforts to consider the use of these health equity measurement approaches in VBP programs, quality reporting efforts, and confidential reports.

¹⁶ 113th Congress of the United States, "H.R.4994 - IMPACT Act of 2014," webpage, 2014. As of January 11, 2021: <https://www.congress.gov/bill/113th-congress/house-bill/4994>

¹⁷ ASPE, *Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*, Washington, D.C.: HHS, 2016; ASPE, *Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*, Washington, D.C.: HHS, 2020.

The objectives of the TEP were to (1) provide feedback on the project team’s proposed definition of a health equity measure and identification of features of health equity measurement approaches; (2) reach consensus on a set of criteria for evaluating health equity measurement approaches for potential inclusion in Medicare’s VBP programs, quality reporting efforts, and confidential reports; and (3) evaluate the set of health equity measurement approaches identified by the team according to these criteria.

The project team synthesized feedback from the TEP to identify the most promising health equity measurement approaches in development and inform potential next steps toward incorporating health equity measures and domains in Medicare’s VBP programs, quality reporting efforts, and confidential reports.

The rest of this report is organized as follows. Chapter 2 describes the literature review methods and results. Chapter 3 provides detailed information on each of the identified health equity measurement approaches, and Chapter 4 provides an integrative summary of these approaches. Chapter 5 provides information about how the TEP was convened and conducted. Chapter 6 describes the input provided by the TEP on the project framing and approach. Chapter 7 describes TEP members’ assessment of and commentary on each of the identified health equity measurement approaches. Chapter 8 provides a summary of the findings of this project and key takeaways for the U.S. Department of Health and Human Services (HHS).

2. Literature Review Methods and Results

The project team conducted a review of articles and reports on health equity measurement approaches developed or intended for use in systematic performance assessment.

Definition of a Health Equity Measurement Approach to Assess Organizational Contributions

We developed a formal definition of a *health equity measure* to guide our search. The definition, which emphasizes performance assessment, is as follows: an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients.¹⁸ Though such an approach is not centered on performance assessment per se, we agreed that an approach focused on structural measures—measures of the extent to which structures, systems, or processes hypothesized to promote the delivery of equitable care are in place within a health care organization—was in scope, given that such measures capture potentially important mechanisms for aligning care and resources with physical, mental, and social needs to optimize health outcomes for all.

Search Strategy

Our search strategy included three approaches. First, we used a structured database search on Ovid MEDLINE and Cumulative Index to Nursing and Allied Health Literature (CINAHL) to identify English-language, peer-reviewed articles published from January 2010 to August 2020. We identified articles using Medical Subject Headings (MeSH) and keywords with at least (1) one health equity or social risk keyword and (2) one performance measurement keyword. Table 2.1 lists the search terms by category. Second, we used a purposive “snowball” approach to identify potentially relevant documents by reference-mining seminal reports (see List 2.1). These are reports that were identified or suggested by health equity measurement experts within the project team and at ASPE. Third, we conducted a gray literature search to identify relevant documents from websites of federal agencies (Centers for Medicare & Medicaid Services [CMS] and ASPE), the National Academy of Medicine, the National Quality Forum (NQF) Quality Positioning System, and the National Quality Measures Clearinghouse. After removing duplicates, our search yielded 783 records, including both published peer-reviewed journal articles and gray literature reports (Figure 2.1).

¹⁸ The National Academy of Medicine (2016) identified five social risk factors that are conceptually likely to be of importance to health outcomes of Medicare beneficiaries: socioeconomic position; race, ethnicity, and cultural context; gender; social relationships; and residential and community context.

Eligibility Criteria

Because our aim was to identify health equity measurement approaches, we sought to exclude articles and reports if they (1) did not describe a specific health equity measurement approach developed or used for the purpose of systematic performance assessment; or (2) were focused on risk adjustment. These exclusions were applied during the article/report screening process described next.

Article/Report Screening

Figure 2.1 illustrates the article/report screening process. We first reviewed titles and abstracts of the 783 documents we identified. To ensure consistent application of our eligibility criteria, three reviewers first independently coded 60 articles across three separate rounds (i.e., 20 articles in each round). Between rounds, reviewers met to discuss independent review outcomes and discrepancies and their application of the criteria, as well as to further refine the definition of each criterion. Disagreements were resolved through discussion or by involving the principal investigator until consensus was reached. Subsequent titles/abstracts were divided, and each was reviewed by one of the three reviewers. Any uncertainties were discussed by the project team together, and all abstracts marked for inclusion were also reviewed by the project team before proceeding to full-text review. We excluded 647 documents at the title/abstract stage that did not meet eligibility criteria.

We then undertook a full text review of 136 documents to identify measurement approaches that would allow health plans or providers to identify areas in which they are performing well or poorly at providing high-quality care to patients with greater social risk factor burden.

Upon full text review, we applied additional exclusions, with the aim of excluding documents that did not articulate a specific health equity measurement approach. Specifically, we excluded (a) documents that described theoretical approaches or frameworks to health equity measurement not currently in development or in use; (b) documents that proposed adjustments to scores or adjustments to payment allocations within an incentive scheme; (c) documents that simply detailed the existence of disparities without the use of a specific measure of disparity; and (d) documents that described the effect of an incentive scheme on disparities. At this stage, we excluded an additional 114 documents that did not meet the eligibility criteria.

Of the 22 documents that met our eligibility criteria, eight fit the fifth category of measurement approaches described above (i.e., measures of the extent to which structures, systems, or processes hypothesized to promote the delivery of equitable care are in place within a health care organization). Because these eight documents all described similar approaches, we opted to include only the most comprehensive of them in our final results. The document that was kept describes a measurement framework for evaluating how well health care organizations comply with national standards for providing culturally and linguistically appropriate services. This document was authored by Davis et al.¹⁹ and describes the results of research commissioned by HHS's Office of

¹⁹ L. M. Davis, L. T. Martin, A. Fremont, R. Weech-Maldonado, M. V. Williams, and A. Kim, *Development of a Long-Term Evaluation Framework for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*, Santa Monica, Calif.: RAND Corporation, EP-68215, 2018.

Minority Health (HHS OMH). The seven documents that we did not include in our final results are in List 2.2. Similarly, four of the 22 documents that met our eligibility criteria were reports of national disparities on patient experience, clinical process and outcome, and patient safety measures. Because these four reports all describe similar approaches to the analysis of disparities, we opted to include just one in our final results. The report that was included is the Agency for Healthcare Research and Quality (AHRQ) *National Healthcare Quality and Disparities Report*.²⁰ The three documents that we did not include in our final results are also in List 2.2. Thus, a total of 11 articles/reports were selected for inclusion in our final results. One of the 11 articles/reports selected for inclusion²¹ describes the analytic foundation underlying another of the reports.²² Thus, although 11 articles/reports were identified, they pertain to only ten total approaches (see Table 2.4 for a summary).

In the following chapters, we describe in detail the ten approaches to health equity measurement described in each of these 11 articles/reports. The description includes information about the approach, the setting and population in which the approach was initially evaluated (if applicable), the social risk factors encompassed by the approach, the outcome measures that factor into the approach, and any available psychometric information reported in the article/report. The description also indicates the features of the approach (see *Features of Health Equity Measurement Approaches* above) and whether the approach has been endorsed by a measure endorsement body or is currently in use in a Medicare VBP or quality reporting program.

²⁰ AHRQ, *2018 National Healthcare Quality and Disparities Report*, Rockville, Md., 2019. As of January 4, 2021: <https://www.ahrq.gov/research/findings/nhqdr/nhqdr18/index.html>

²¹ S. C. Martino, R. M. Weinick, D. E. Kanouse, J. A. Brown, A. M. Haviland, E. Goldstein, J. L. Adams, K. Hambarsoomian, D. J. Klein, and M. N. Elliott, "Reporting CAHPS and HEDIS Data by Race/Ethnicity for Medicare Beneficiaries," *Health Services Research* Vol. 48, No. 2 Pt 1, 2013, pp. 417–434.

²² OMH, "Part C and D Performance Data Stratified by Race, Ethnicity, and Gender," database, Centers for Medicare and Medicaid Services, 2020. As of January 4, 2020: <https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting.html>

Table 2.1. Database Search Strategy

Concept	MeSH	Search Terms
Health equity	Health equity; healthcare disparities	Equity; disparit*
Social risk	Social determinants of health; socioeconomic factors; safety-net providers	Social determinants; social risk; safety net; race; ethnicity
Performance measurement	Value-based purchasing; incentive reimbursement	Performance measure; quality measure; value-based purchasing; pay for performance; quality reporting; public reporting; CAHPS; HEDIS

NOTE: The search syntax was as follows:

1. "health equity".sh,kf.
2. "healthcare disparities".sh.
3. "equity".ti,ab.
4. "disparit*".ti,ab.
5. "social determinants of health".sh.
6. "social determinants".ti,ab.
7. "social risk".ti,ab.
8. "socioeconomic factors".sh.
9. "safety-net providers".sh.
10. "safety net".ti,ab.
11. "race".ti,ab.
12. "ethnicity".ti,ab.
13. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12
14. "value-based purchasing".ti,ab,sh.
15. "reimbursement, incentive".sh.
16. "performance measure".ti,ab,kf.
17. "quality measure".ti,ab,kf.
18. "pay for performance".ti,ab.
19. "quality reporting".ti,ab.
20. "public reporting".ti,ab.
21. "CAHPS".ti,ab.
22. "HEDIS".ti,ab.
23. 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22
24. 13 and 23
25. limit 24 to English language
26. limit 25 to yr="2010-Current"

List 2.1. Seminal Reports Mined as Part of Our Purposive Snowball Approach

Anderson, A. C., E. O'Rourke, M. H. Chin, N. A. Ponce, S. M. Bernheim, and H. Burstin, "Promoting Health Equity and Eliminating Disparities Through Performance Measurement and Payment," *Health Affairs*, Vol. 37, No. 3, 2018, pp. 371–377.

ASPE Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs (Study A), 2016.

ASPE Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs (Study B), 2020.

Damberg, C. L., M. N. Elliott, and B. A. Ewing, "Pay-for-Performance Schemes That Use Patient and Provider Categories Would Reduce Payment Disparities," *Health Affairs*, Vol. 34, No. 1, 2015, pp. 134–142.

Hughes, D., J. Levi, J. Heinrich, and H. Mittmann, *Developing a Framework to Measure the Health Equity Impact of Accountable Communities for Health*, Washington, D.C.: Funders Forum on Accountable Health, 2020.

National Academies of Science, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*, Washington, D.C.: National Academies Press and HHS, 2016.

List 2.2. Articles and Reports That Met Eligibility Criteria but Were Not Included in the Final Results

Articles and reports describing measures of structures, systems, and processes within a health care organization that promote delivery of equitable care

- Hughes, D., J. Levi, J. Heinrich, and H. Mittmann, *Developing a Framework to Measure the Health Equity Impact of Accountable Communities for Health*, Washington, D.C.: Funders Forum on Accountable Health, 2020.
- *Cultural Competency 2010 Measures and Implementation Strategies*, Washington, D.C.: NQF, 2011.
- *Healthcare Disparities and Cultural Competency Consensus Standards Technical Report*, Washington D.C.: NQF, 2012.
- Ng, J. H., M. A. Tirodkar, J. B. French, H. E. Spalt, L. M. Ward, S. C. Haffer, N. Hewitt, D. Rey, and S. H. Scholle, "Health Quality Measures Addressing Disparities in Culturally and Linguistically Appropriate Services: What are Current Gaps?" *Journal of Health Care for the Poor and Underserved*, Vol. 28, No. 3, 2017, pp. 1012–1029.
- Weech-Maldonado, R., A. Carle, B. Weidmer, M. Hurtado, Q. Ngo-Metzger, and R. D. Hays, "The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence (CC) Item Set," *Medical Care*, Vol. 50, No. 9, Suppl 2, 2012, pp. S22–S31.
- Weech-Maldonado, R., J. Dreachslin, J. Brown, R. Pradhan, K. L. Rubin, C. Schiller, and R. D. Hays, "Cultural Competency Assessment Tool for Hospitals (CCATH): Evaluating Hospitals' Adherence to the CLAS Standards," *Health Care Management Review*, Vol. 37, No. 1, 2012, pp. 54–66.
- Weech-Maldonado, R., M. N. Elliott, J. L. Adams, A. M. Haviland, D. J. Klein, K. Hambarsoomian, C. Edwards, J. W. Dembosky, and S. Gaillot, "Do Racial/Ethnic Disparities in Quality and Patient Experience Within Medicare Plans Generalize Across Measures and Racial/Ethnic Groups?" *Health Services Research*, Vol. 50, No. 6, 2015, pp. 1829–1849.
- Weech-Maldonado, R., M. Elliott, et al. "Can Hospital Cultural Competency Reduce Disparities in Patient Experiences with Care?" *Medical Care*, Vol. 50, 2012, pp. S48–S55.

Reports of national disparities in health care

- *The National Impact Assessment of CMS Quality Measures Reports*, Baltimore, Md.: CMS, February 2020.
 - Martino, S. C., M. N. Elliott, J. W. Dembosky, K. Hambarsoomian, Q. Burkhardt, D. J. Klein, J. Gildner, and A. M. Haviland, *Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage*, Baltimore, Md: CMS OMH, 2020.
 - Martino, S. C., M. N. Elliott, J. W. Dembosky, K. Hambarsoomian, Q. Burkhardt, D. J. Klein, J. Gildner, and A. M. Haviland, *Rural-Urban Disparities in Health Care in Medicare*, Baltimore, Md.: CMS OMH, 2019.
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Figure 2.1. Literature Review Flow Diagram

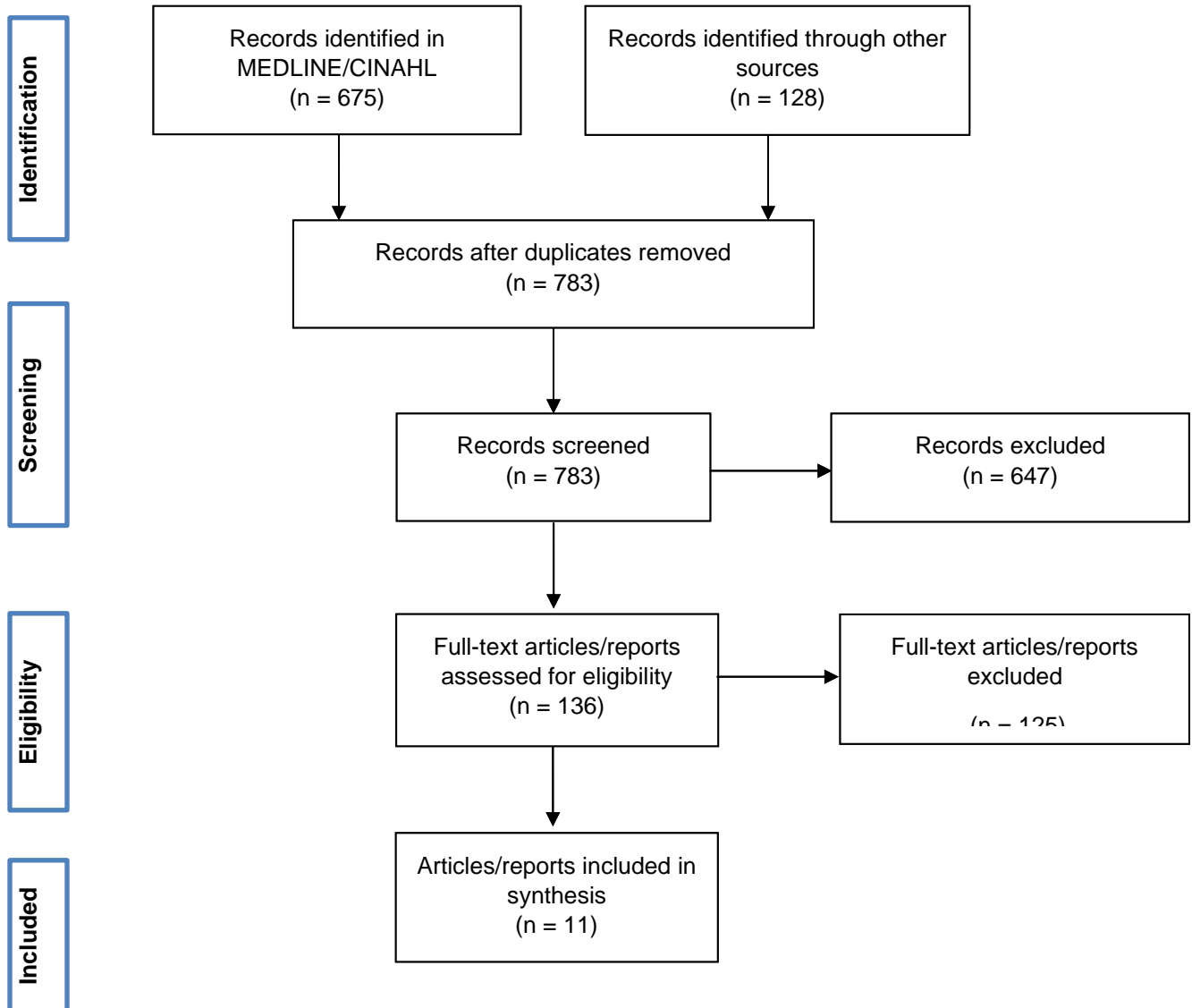


Table 2.2. Summary of the Health Equity Measurement Approaches Identified by the Literature Review

Measurement Approach	Setting/Population	Social Risk Factor(s)
1. Measurement Framework for Evaluating How Well an Organization Meets National Standards for Culturally and Linguistically Appropriate Services (HHS OMH)	Health care organizations	Race/ethnicity; limited English proficiency; low literacy
2. NQF Disparities-Sensitive Measure Assessment	Cross-cutting	Race/ethnicity
3. AHRQ <i>National Healthcare Quality and Disparities Report</i>	Overall U.S. population	Age; sex, race/ethnicity
4. CMS OMH Mapping Medicare Disparities Tool	Medicare FFS	Race/ethnicity; dual eligibility; sex; age
5. CMS OMH Reporting of CAHPS and HEDIS Data by Race/Ethnicity for Medicare Beneficiaries	MA and prescription drug plans, Medicare FFS	Race/ethnicity
6. <i>Minnesota Healthcare Disparities Report</i>	Minnesota health plan enrollees	Race, ethnicity, preferred language, country of origin
7. CMS Assessment of Hospital Disparities for Dual-Eligible Patients	Hospitals	Dual eligibility
8. CMS OMH Health Equity Summary Score	Medicare Advantage plans	Race/ethnicity; dual eligibility
9. Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity	General adult U.S. population	Race/ethnicity; sex; income
10. Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity	General adult U.S. population	Race/ethnicity; sex; income

NOTE: CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; DHHS = U.S. Department of Health and Human Services; FFS = fee-for-service; HEDIS = Healthcare Effectiveness Data and Information Set; MA = Medicare Advantage; NQF = National Quality Forum; OMH = Office of Minority Health

3. Detailed Information on Identified Approaches

In this chapter, we describe in detail the health equity measurement approaches that were identified by the literature described in the preceding chapter. A summary of these measurement approaches appears in the following chapter, which also introduces a categorization scheme by which the measurement approaches are ordered here and elsewhere.

Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards (HHS OMH)

Overview. This report—which was commissioned by HHS OMH— describes a framework for measuring whether structures, systems, or processes hypothesized to promote health equity are in place within a health care organization or system.²³

Background. The National CLAS Standards are a set of 15 standards intended to advance health equity and help eliminate health care disparities by providing a blueprint for health care organizations to implement culturally and linguistically appropriate services. The essential goal of the standards is framed in the *Principal Standard*: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The other 14 standards address domains of governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability.

Design and methods. The goal of this approach is to identify a set of well-constructed and validated health equity process and impact measures that could be applied to four settings of care— ambulatory care, hospitals, behavioral health, and public health—to evaluate how well a health care organization meets the National CLAS Standards. Specific criteria were used by the authors of this framework to identify salient measures to consider, including whether the measure (a) assesses cultural competency; (b) captures language needs or preferences and/or is linked to other CLAS-related issues; (c) documents disparities; (d) is validated and/or psychometrically tested; (e) is widely used or suitable for use by a range of health care organizations; (f) has been previously endorsed in commissioned projects or reports for evaluating disparities; and (g) cuts across conditions and/or settings. Measures were categorized as cross-cutting (i.e., applicable across multiple settings) or setting-specific. Based on the criteria, the authors identified six cross-cutting measures (see Table 3.1), six ambulatory-specific measures, nine hospital-specific measures, five behavioral health-specific measures, and six public health-specific measures. Appendix A shows measures that fit the latter four categories.

²³ L. M. Davis, L. T. Martin, A. Fremont, R. Weech-Maldonado, M. V. Williams, and A. Kim, *Development of a Long-Term Evaluation Framework for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*, Santa Monica, Calif.: RAND Corporation, EP-68215, 2018.

Table 3.1. Cross-Cutting Measures to Evaluate How Well an Organization Meets National CLAS Standards

Measure	Description
Clinician/group's cultural competence based on the CAHPS Cultural Competence Item Set	Domains from CAHPS Cultural Competence Item Set: patient-provider communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and confidence in the truthfulness of a provider; and linguistic competency (access to language services)
Clinician/group's health literacy practices based on the CAHPS Item Set for Addressing Health Literacy	Domains from CAHPS Item Set for Addressing Health Literacy: communication with provider, disease self-management, communication about medicines, communication about test results, and communication about forms.
Patients receiving language services supported by qualified language services providers	Percentage of patients with limited English proficiency receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency
Screening for preferred spoken language for health care	Percentage of patient visits and admissions in which the preferred spoken language for health care is screened and recorded.
Cultural Competency Implementation Measure	Survey of degree to which health care organizations are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed cultural competency practices.
Communication Climate Assessment Toolkit	360-degree organizational assessment using coordinated patient, staff, and leadership surveys, as well as an organizational workbook that collects important information on the organization's policies and practices.

NQF Disparities-Sensitive Measure Assessment

Overview. This report presents a protocol to systematically screen and identify NQF-endorsed measures as disparities-sensitive.²⁴ The set of measures identified by this approach was developed for use across health care settings.

Background. To establish a platform for addressing health care disparities and cultural competency in measurement, NQF sought to identify measures from within its existing portfolio of endorsed measures that might be disparities-sensitive (see below). In particular, NQF sought to identify measures sensitive to health care disparities and cultural competency for racial and ethnic minority populations. They established criteria to evaluate measures for how sensitive they were to disparities, assigned points to each measure based on these criteria, and set point thresholds and other rules to identify disparities-sensitive measures.

Design and methods. To evaluate existing measures for disparities sensitivity, two tiers of criteria were established that placed emphasis on prevalence and impact of the condition, quality gap, and impact of the quality process.²⁵ The first-tier criteria—applied to condition-specific measures and measures of health care access and quality—included the prevalence of the condition among minority groups, the size of the gap in the quality of care between disadvantaged and advantaged groups, and the impact the condition has financially or societally. The second-tier criteria—applied to process measures that could be used to improve performance in health equity—included communication-sensitive practices; specifically, whether the measure mapped to either the NQF-endorsed competency framework domain or the care coordination framework domain.

Based on these criteria, a simple scoring system was applied to evaluate over 500 measures in the existing NQF portfolio. For condition-specific measures, 3 points were given for specific conditions such as cancer, diabetes, and heart disease and 2 points for measures on a list of top 20 conditions among Medicare beneficiaries, such as substance abuse or obesity. Cross-cutting areas, such as patient safety, functional status, or pain management, were given 3 points. All other condition-specific measures were given 1 point. Similarly, the greater the size of the quality gap between disadvantaged and advantaged groups, the more points were assigned; e.g., a 0-percent to 2-percent quality gap was assigned 1 point, while a quality gap greater than 14 percent was given 4 points. To reflect impact, 1 point was assigned for each National Quality Strategy priority area or goal addressed, and 1 point each for whether a condition was a leading cause of morbidity/mortality overall, was associated with high resource use, had high severity of illness, or

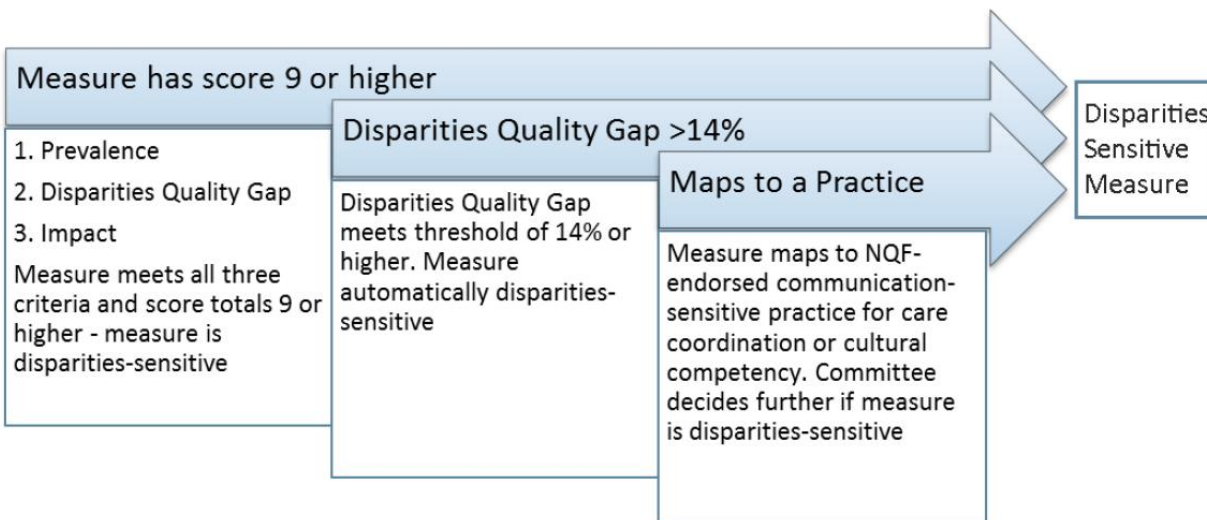
²⁴ *Healthcare Disparities and Cultural Competency Consensus Standards: Disparities Sensitive Measure Assessment*, NQF Technical Report, Washington, D.C., 2012. As of January 4, 2021: https://www.qualityforum.org/Publications/2012/11/Healthcare_Disparities_and_Cultural_Competency_Consensus_Standards_Disparities-Sensitive_Measure_Assessment.aspx. Also see NQF, *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity*, Washington, D.C., 2017. As of January 4, 2021: http://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities_The_Four_I's_for_Health_Equity.aspx

²⁵ Measures addressing the National Quality Strategy priority areas or goals were judged to fit this criterion, as were measures assessing a high-impact aspect of health care (e.g., conditions affecting large numbers, leading causes of morbidity and mortality, conditions leading to high resource use, and severe illnesses).

was one for which poor quality would be consequential. Finally, 2 points were given to any measures that mapped to the two NQF-endorsed framework domains.

To select measures, NQF emphasized prevalence, the threshold of the quality gap, impact, and whether a measure could be mapped to an NQF-endorsed framework domain addressing care coordination or cultural competency (Figure 3.1). If the measure scored 9 or higher on the first-tier criteria, the measure was considered disparities-sensitive. Further, if the quality gap was 14 percent or higher, the measure was also automatically considered disparities-sensitive. The NQF analysis found that measures that fit within the highest quality-gap quartile also had the highest first-tier score, which identified an initial set of 62 measures deemed disparities-sensitive. Additional analysis of whether a measure mapped to an NQF-endorsed framework domain identified another 14 measures, for a total of 76 disparities-sensitive measures. These measures are listed in Appendix B.

Figure 3.1. NQF Disparities-Sensitive Measure Identification



AHRQ National Healthcare Quality and Disparities Report

Overview. This report describes approaches to measuring and reporting providers' performance for patients with social risk factors versus without them, and also measures health disparities specifically using methods for formally comparing performance between patients with social risk factors versus without them.²⁶ The approaches are applied to the overall U.S. population. Data come from a large number of national surveys and databases maintained by several federal agencies, including AHRQ, CMS, the Centers for Disease Control and Prevention, the Indian Health Service, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Health Resources and Services Administration.²⁷

Background. The AHRQ National Healthcare Quality and Disparities Report is an annual report mandated by Congress to provide a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different racial and socioeconomic groups. It includes information on disparities in access to care and quality of care in the most recent data year, as well as changes in disparities over time. The report also includes information on federal initiatives to reduce disparities. The social risk factors addressed include age, sex, and race and ethnicity. In this report, comparisons are made between a reference group²⁸ and a *priority population* group based on a population characteristic, such as sex (i.e., women versus men) or minority racial and ethnic groups versus Whites. The report includes more than 250 structure, process, and outcome measures covering a broad array of health care services and settings. For example, the report provides data on access to health care, patient experience, patient safety, maternal and child health, functional status preservation and rehabilitation, supportive and palliative care, health promotion, clinical preventive services, use of effective treatments, care coordination, care affordability, morbidity, and mortality.

Design and methods. All measures are scored as percentages. Two criteria are applied to identify meaningful differences in measure performance between two groups in the single current, or most recent, data year. First, the absolute difference in measure performance between the priority population group and the reference group must be statistically significant with $p < 0.05$ on a two-tailed test. Second, the relative difference between the two groups must be at least 10 percent when framed positively or negatively (i.e., in either direction). For example, performance on the measure could be 10 percent higher in the reference group than the priority group, and that would be characterized as a *meaningful difference*, or *disparity*.

To evaluate changes in disparities over time, the average annual change (AAC) in measure performance for each group is first calculated as the coefficient in an unweighted regression analysis that estimates performance in at least four time points between 2000 and the most recent data year for both the priority and the reference groups. Then, the AAC of the reference group is

²⁶ AHRQ, *2018 National Healthcare Quality and Disparities Report*, Rockville, Md., 2019. As of January 4, 2021: <https://www.ahrq.gov/research/findings/nhqdr/nhqdr18/index.html>

²⁷ More information about data sources can be found in the *2018 National Healthcare Quality and Disparities Report Data Sources*, Rockville, Md.: AHRQ, October 2019. As of January 4, 2021: <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/2018qdr-datasources.pdf>

²⁸ Use of the term *reference group* here mirrors that found in the AHRQ report.

subtracted from the AAC for the priority group, and the difference is tested for statistical significance. The disparity is characterized as *improving* over time if the difference between the AAC of the priority population and reference group was less than -1 percentage point (i.e., in a favorable direction), and the test of the difference had a p-value < 0.10 . The disparity is characterized as *worsening* if the difference in the AAC between the groups was more than 1 percentage point and the test of the difference had a p-value < 0.10 . Finally, the disparity is characterized as *not changing* if the absolute value of the AAC difference was less than 1 percentage point or the absolute value of the difference in the AAC was greater than 1 percentage point and the p-value of the test of the difference was ≥ 0.10 .

CMS OMH Mapping Medicare Disparities Tool

Overview. This tool was developed to measure and report providers' performance for Medicare FFS beneficiaries with social risk factors versus without them. Social risk factors addressed include race, ethnicity, dual eligibility, sex, and age. The Mapping Medicare Disparities (MMD) Tool is published on the CMS OMH website.²⁹

Background. The CMS OMH MMD Tool is an online interactive map that illustrates comparisons of disparities between groups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending. The tool offers two types of comparisons: The *Hospital View* visually compares hospital performance on a range of metrics and performance scores categorized by geography (e.g., county, state, and national), hospital type (e.g., acute care and critical access), hospital ownership (e.g., government, physician, proprietary, tribal, and voluntary), and/or hospital size (i.e., number of beds). This view does not allow comparisons of hospital performance specifically for different social risk factor groups; it allows comparisons only of hospital performance overall. However, pertinent to the current effort, the *Population View* compares groups according to social risk factors (such as race and ethnicity, age, sex) on their condition prevalence and on health care utilization, quality, and spending.

Design and methods. The MMD Tool draws on data from CMS administrative enrollment and claims data for Medicare beneficiaries enrolled in Medicare FFS and includes hundreds of measures over three dozen conditions.³⁰ The Population View provides descriptive statistics by social risk factor group on indicators such as Medicare spending, hospital and emergency department utilization, preventable hospitalizations, readmission rates, risk-standardized 30-day all-cause mortality rates for acute myocardial infarction and heart failure, and discharge destinations for a range of conditions. In this Population View, measures can be examined at both state and county levels, or by urban versus rural locations. Comparisons can be made against the national, state, or county average for a given measure. However, no statistical comparisons are made.

²⁹ Office of Minority Health, "Mapping Medicare Disparities," online tool, Centers for Medicare and Medicaid Services, 2020. As of January 4, 2021: <https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities>

³⁰ Detail on these measures can be found in NORC at the University of Chicago, "The Mapping Medical Disparities Tool: Technical Documentation," Version 8.0, HHS OMH, July 30, 2020. As of January 4, 2021: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Mapping-Technical-Documentation.pdf>

CMS OMH Reporting of CAHPS and HEDIS Data Stratified by Race and Ethnicity for Medicare Beneficiaries

Overview. This is an approach to measuring and reporting care provided to Medicare beneficiaries with social risk factors versus without them. This approach is currently used to report Medicare Part C and D performance data at contract and state levels stratified by race and ethnicity on the CMS OMH website.³¹ This stratified reporting will be extended to include rural and urban comparisons in 2021.

Background. The CMS OMH has reported Medicare FFS, Part C, and Part D performance data, stratified by race and ethnicity (specifically, Asian or Pacific Islander, Black, Hispanic, and White) annually since 2015. The purpose of stratified reporting in this context is to provide information for targeting quality improvement activities and resources, to monitor MA and prescription drug plan (PDP) performance, and to advance the development of culturally and linguistically appropriate quality improvement strategies. Stratified estimates of performance by social risk factor are provided for individual MA contracts, individual PDP contracts, and states (FFS). Statistical comparisons of contract scores are made to the national average for a particular racial or ethnic group.

Design and methods. Under this stratified reporting approach, patient experience (from the CAHPS survey) and clinical quality (from HEDIS) measures are evaluated for inclusion in reporting according to two criteria: *reliability*, which is the extent to which a given measure is able to distinguish true differences among plans for a given racial or ethnic group, and *informativeness*, which reflects the amount of information about minority group scores that are not contained in scores for Whites.³² This latter criterion assesses whether stratification of data by racial and ethnic groups provides enough new information about plan performance to justify the loss in precision that comes from basing estimates on fewer observations (i.e., a smaller sample). The approach imposes certain minimum sample requirements for reporting a measure; specifically, at least 100 measure completes for MA contracts and 200 measure completes for individual PDP contracts for a given racial or ethnic group. Two years of data are combined in each report to increase sample sizes. Scores that do not meet the minimum sample size threshold or for which reliability is < 0.60 are not reported; scores that meet the sample size requirement and for which reliability is between 0.60 and 0.70 are reported but flagged as having low reliability.

³¹ OMH, “Part C and D Performance Data Stratified by Race, Ethnicity, and Gender,” database, CMS, 2020. As of January 4, 2021: <https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting.html>

³² S. C. Martino, R. M. Weinick, D. E. Kanouse, J. A. Brown, A. M. Haviland, E. Goldstein, J. L. Adams, K. Hambarsoomian, D. J. Klein, and M. N. Elliott, “Reporting CAHPS and HEDIS Data By Race/Ethnicity For Medicare Beneficiaries, *Health Services Research*, Vol. 48, No. 2 Pt 1, 2013, pp. 417–434.

Minnesota Healthcare Disparities Report

Overview. This measurement approach pertains to Minnesota health plan enrollees and is used to measure, formally compare, and report providers' performance for plan members with social risk factors versus without them. Key social risk factors addressed include race and ethnicity, preferred language, and country of origin. The report is authored by MN Community Measurement—an independent collaborative organization that collects, analyzes, and reports regional data on health care quality and cost—and is published on this organization's website.³³

Background. MN Community Measurement publicly reports comparative data on health care performance for Minnesota patients enrolled in state and federally funded public programs and private or Medicare-managed programs.³⁴ Their *Minnesota Healthcare Disparities Report* describes medical group performance on health care process and outcomes using 12 HEDIS measures, stratified by race, Hispanic ethnicity, preferred language, and country of origin. These measures include

- optimal diabetes care (HEDIS composite measure)
- optimal vascular care (HEDIS composite measure)
- optimal asthma control, adults
- optimal asthma control, children
- colorectal cancer screening
- adolescent mental health and/or depression screening
- adult depression: follow-up at six and 12 months; response at six and 12 months; remission at six and 12 months.

Composites comprise multiple standard HEDIS measures. For example, optimal diabetes care is defined as achieving or meeting all of the following: (a) HbA1c less than 8.0 mg/dL; (b) blood pressure less than 140/90 mm Hg; (c) on a statin medication, unless allowed contraindications or exceptions are present; (d) non-tobacco user; and (e) patient with ischemic vascular disease on daily aspirin or antiplatelets, unless allowed contraindications or exceptions are present.

Design and methods. In this approach, data are reported at two levels. At the state level, social risk factor groups are compared with each other (e.g., White females versus White males, non-English-speaking Black patients versus English-speaking Black patients) and with the overall state average and state average for the social risk factor group for each measure. At the medical group level, social risk factor groups are compared with the overall state average and state average for the social risk factor group. Minimum sample sizes are required to permit reporting; for standard HEDIS measures, a minimum threshold of 30 patients per medical group is required for public recording. For composite measures, the minimum threshold for reporting is 60 patients per medical group.

³³ MN Community Measurement, *Minnesota Health Care Disparities by Race, Hispanic Ethnicity, Language and Country of Origin: 2019 Report*, Minneapolis, Minn., May 2020. As of January 4, 2021: <https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20RELC/2019%20Disparities%20by%20RELC%20Chartbook%20-%20FINAL.pdf>

³⁴ A. M. Snowden, V. Kunerth, A. M. Carlson, J. A. McRae, and E. Vetta, "Addressing Health Care Disparities Using Public Reporting," *American Journal of Medical Quality*, November 19, 2011.

Race, ethnicity, language, and country of origin data are submitted by medical groups and clinics directly to Minnesota Community Measurement for analysis and reporting, utilizing an extensive extraction and validation process to ensure that medical groups collect these data elements from patients using best practices. The best practices include that

- patients self-report their race and Hispanic ethnicity
- patients have the option to select one or more categories for race (i.e., medical groups/clinics do not collect data using a multiracial category).

Medical groups and clinics must adhere to all of the above best practices for collecting these social risk factor data to be included in the rate calculation.

CMS Assessment of Hospital Disparities for Dual-Eligible Patients

Overview. This approach³⁵ compares outcomes of care for dual-eligible Medicare beneficiaries across hospitals and quantifies disparities between dual-eligible and non-dual-eligible beneficiaries within the same hospital. It focuses on one specific social risk indicator, dual eligibility status, and one outcome measure, unplanned readmission following hospitalization for pneumonia.

Background. This approach is used in confidential reporting to hospitals and focuses on reporting disparities in performance to inform quality improvement efforts. The outcome measure is specified as the number of unplanned readmissions within 30 days of discharge for Medicare beneficiaries 65 years and older who were hospitalized at short-term acute care hospitals following an index admission for pneumonia. The pneumonia measure cohort includes patients aged 65 years or older enrolled in Medicare FFS in the prior year with a principal discharge diagnosis of pneumonia or sepsis with secondary discharge diagnosis of pneumonia coded present on admission. The measure is constructed using Medicare administrative claims and enrollment data.

Design and methods. Hospital performance on this measure is calculated using two complementary approaches: The Within-Hospital Disparity Method measures the difference in outcomes between patients who are dually eligible³⁶ and patients who are not dually eligible within a hospital; the Dual Eligible Outcome Method compares performance on the outcome for dually eligible patients across hospitals. For both approaches, the outcome is adjusted for patient age and medical conditions at the time of admission and 12 months prior. Results are reported for hospitals with at least 25 patients overall and 12 patients per group (dual-eligible and non-dual-eligible patients).

The Within-Hospital Disparity Method calculates, for each hospital, an absolute rate difference in the outcomes between patients who are dual-eligible versus those who are not, within that hospital. As an absolute value, this method does not consider the direction of the disparity. Under this method, levels of hospital performance are characterized in two ways: (1) the distribution of the absolute value of the absolute rate difference is divided into ten equal categories; hospitals falling in higher deciles have larger within-hospital disparity; and (2) a statistical test of the difference of the disparity from zero.

The Dual Eligible Outcome Method measures and compares hospital performance for the subgroup of patients who are dual-eligible by calculating a risk-standardized readmission rate (RSRR) for dual-eligible patients for each hospital. This method also characterizes performance levels in two ways: (1) the distribution of the dual-eligible specific RSRRs is divided into ten equal categories; hospitals falling in higher deciles have high dual-specific RSRRs; and (2) a statistical test of the difference of the RSRR from the national readmission rate of dual-eligible patients, such that performance is worse, no different, or better than the national rate for dual-eligible patients.

³⁵ Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation, *Assessing Hospital Disparities for Dual Eligible Patients: Thirty-Day All-Cause Unplanned Readmission Following Pneumonia Hospitalization*, New Haven, Conn., 2018. Disparity methods confidential reporting overview, as of January 5, 2021: <https://www.qualitynet.org/inpatient/measures/disparity-methods>; disparity methods confidential reporting methodology, as of January 5, 2021: [qualitynet.org/inpatient/measures/disparity-methods/methodology](https://www.qualitynet.org/inpatient/measures/disparity-methods/methodology)

³⁶ The demonstration of this approach was focused on full dual eligible beneficiaries.

CMS OMH Health Equity Summary Score

Overview. The Health Equity Summary Score (HESS)³⁷ is a summary health equity metric that is designed to promote and incentivize excellent care for racial and ethnic minorities and dual- and Low-Income-Subsidy (LIS)–eligible MA beneficiaries. The HESS can be used to compare performance for patients with social risk factors across providers or assess improvement in performance for providers' socially at-risk populations over time, both within contracts and between contracts.

Background. The HESS is designed to measure both current (cross-sectional) quality of care and quality improvement and to incentivize good care to both racial and ethnic minorities and beneficiaries who are dually eligible for Medicare and Medicaid or eligible for a LIS under Medicare Part D (referred to as *DE/LIS eligible*). The HESS summarizes performance across two types of data: (1) patient experience, as measured by CAHPS: doctor communication, ease of getting needed care, getting care quickly, ease of getting needed prescription drugs, customer service, care coordination, and flu immunization; and (2) clinical care, as measured by HEDIS: breast cancer screening, colorectal cancer screening, diabetes care (both nephropathy and retinal exam), and adult body mass index assessment. Both types of data are linkable to social risk factors at the level of the individual Medicare beneficiary, and the measures that are included in the HESS are continually evaluated for their suitability for inclusion.

Design and methods. The cross-sectional component of the HESS combines the two most recent years of data, while the improvement (i.e., performance over time) score compares performance in the two most recent years with performance in the two years prior. To assure accurate measurement, a plan's HESS is based only on the combination of social risk factor groups and measures for which there is sufficient sample size of 100 and reliability greater than or equal to 0.7. For improvement measures, this must hold at both baseline and follow-up. For each measurable MA contract, the HESS is based on however many social risk factor groups can be reliably measured, and information is combined to give equal weight to each social risk factor group. To be eligible to receive a HESS score, an MA contract must have a minimum of 500 enrollees and publicly reported quality scores, including a Medicare Part C summary rating and at least one CAHPS or HEDIS Medicare Star rating.

The process for calculating the HESS is visually depicted in Figure 4.2. Cross-sectional performance for each measurable racial and ethnic minority group and for DE/LIS-eligible beneficiaries is estimated using linear models, yielding one score for each social risk factor group for each measure. All measures are rescaled to a 0–100 scale and modeled separately, and estimates are standardized to put them on a common scale across measures and groups. The standardized estimates are then combined across measures and social risk factor groups to yield a single cross-sectional performance score for each MA contract. Performance scores are converted to a five-star scale

³⁷ D. Agniel, S. C. Martino, Q. Burkhart, K. Hambarsoomian, N. Orr, M. K. Beckett, C. James, S. H. Scholle, S. Wilson-Frederick, J. Ng, and M. N. Elliott, "Incentivizing Excellent Care to At-Risk Groups with a Health Equity Summary Score," *Journal of General Internal Medicine*, November 2019.

using the Medicare Part C clustering algorithm.³⁸ Improvement scores combine both a within-plan component and a between-plan, or benchmarked, component. The within-plan component measures the narrowing or widening of within-plan disparities (between the two-year baseline period and the two-year performance period) and compares—measure by measure—performance for all lagging groups to performance for the leading group (i.e., the group with the highest baseline score on a measure) of each contract. The between-plan or nationally benchmarked component measures the improvement of each social risk factor group compared with that group’s national average improvement. As with the cross-sectional score, this procedure is undertaken for each measurable racial and ethnic minority group and for DE/LIS beneficiaries. Cross-sectional and improvement scores are blended according to the scheme in Figure 4.3. As the figure shows, low improvement scores cannot result in a blended score lower than a plan’s cross-sectional score, which prevents high-performing plans from being penalized for what may be necessarily limited improvement. By design, improvement counts more toward a contract’s HESS when cross-sectional performance is lower, to encourage and reward improvement for low-performing plans. For example, as can be seen in Figure 4.3, a contract that scores one star on the cross-sectional component of the HESS can earn an additional blended star if it achieves four stars for improvement, and it can earn two additional blended stars if it achieves five stars for improvement. Finally, a contract’s HESS is computed by averaging its blended score for race and ethnicity and its blended score for DE/LIS to produce a final composite score. Composite HESS scores are generated separately for clinical care and patient experience.

³⁸ CMS, “Medicare 2020 Part C & D Star Ratings Technical Notes,” October 2019. As of January 5, 2021: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf>

Figure 4.2. Components of the HESS

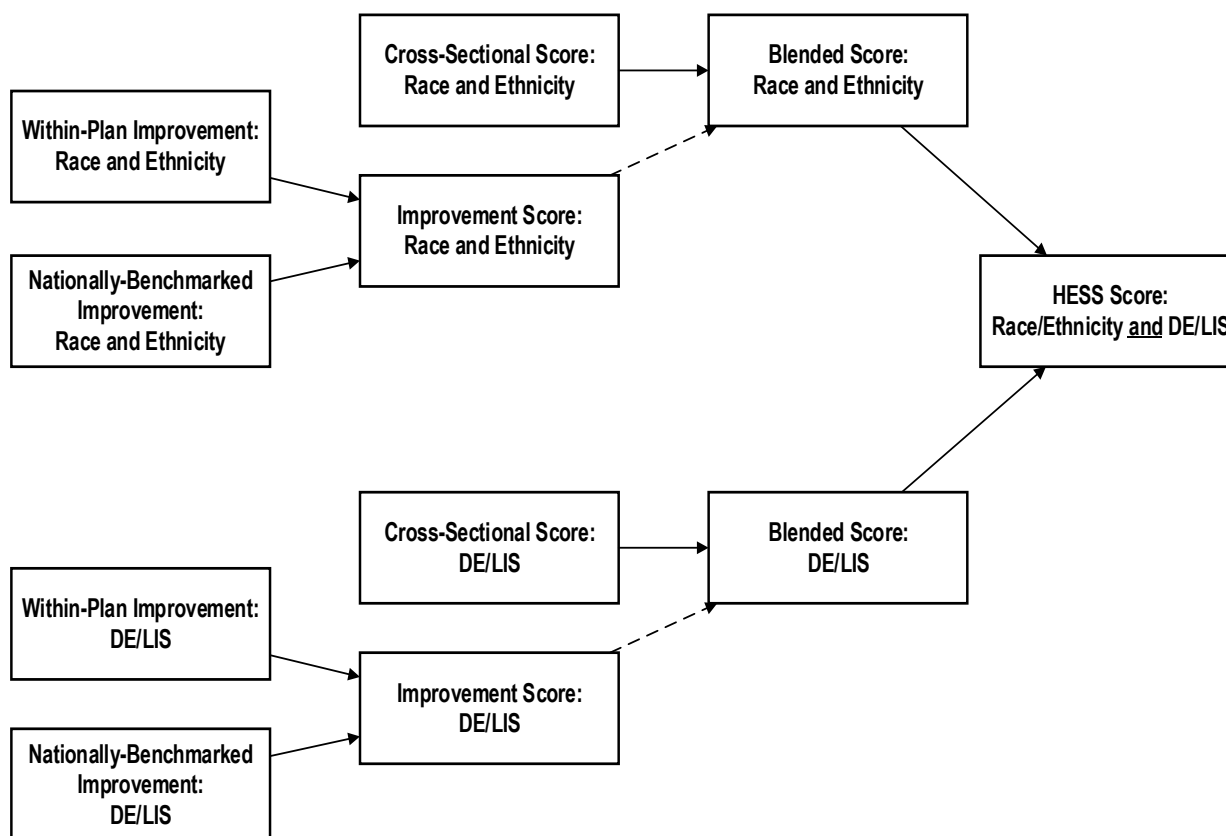


Figure 4.3. HESS: Blending Scheme

		Improvement stars					
		missing	1	2	3	4	5
Cross-sectional stars	1	1	1	1	1	2	3
	2	2	2	2	2	3	3
	3	3	3	3	3	3	4
	4	4	4	4	4	4	5
	5	5	5	5	5	5	5

Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity

Overview. Like the HESS, this approach by Zimmerman³⁹ synthesizes information across multiple measures, in this case using a health-related quality of life criterion. The approach is oriented toward quantifying the total deviation of a population from a defined privileged group and allows disaggregation, e.g., to the level of states.

Background. This health equity measure compares the average health-related quality of life of individuals within numerous social categories (race, ethnicity, sex, and income) to the average quality of life of individuals from a privileged social category: specifically, high-income White men. The assumption undergirding this measure is that wealthy White men hold the highest social privilege in the United States, and therefore it is their experience that is the relevant comparison standard. Moreover, while the identities of socially marginalized groups have changed over time, as have the ways in which marginalization translates into health outcomes, the privileged status of upper-income White men has been stable for decades. In using wealthy White men as the comparator, the measure implicitly treats gender, race, and income as the social risk factors of interest. The health experiences of all those who do not belong to the privileged group are included in the computation of the measure, though scores for specific subgroups (e.g., low-income Black women) can be derived.

Design and methods. The proposed measure conceptually defines *health disutility* as the “distastefulness” associated with one’s health falling short of the optimal achievable health. To build this approach, 2017 Behavioral Risk Factor Surveillance System data were used from adults aged 18 to 64 years from all 50 states and the District of Columbia. The key outcome is a measure of *healthy days* derived from the Centers for Disease Control and Prevention’s health-related quality of life scale. This scale was constructed by summing the answers to two questions about how many days in the previous 30 days the respondent felt that their mental or physical health was not good, rescaled such that higher scores equal more healthy days and age-adjusted. To calculate the measure, for each state, a health deficit was defined for each individual in the group as the amount by which their health falls below the average health in the most privileged group. The metric can be summed over the total state population to get the mean value of distastefulness for the state or can be summed over specific social groups, for example, to show how the health of low-income Black women compares with the health of the privileged group within that state.

³⁹ F. J. Zimmerman, “A Robust Health Equity Metric,” *Public Health*, Vol. 175, 2019, pp. 68–78.

Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity

Overview. This approach by Zimmerman and Anderson⁴⁰ focuses on changes in patterns of health disparities and health equity over a 25-year period at different geographic levels and summarizes that information using a health-related quality of life criterion. In many ways, this is a longitudinal counterpart to the approach described on the previous page. Here, too, the social risk factors encompassed by the method are race and ethnicity, sex, and income.

Background. Health equity is defined across multiple dimensions, including health disparities, or differences in health outcomes among groups; health inequality, or the overall variation in health across individuals without regard to social group; and health justice, or the correlation of health outcomes with social attributes, e.g., economic status.

Design and methods. To build the approach, 25 years of Behavioral Risk Factor Surveillance System data from adults aged 18 to 64 years were used to assess two key outcomes: self-reported general health on a 5-point scale (excellent, very good, good, fair, poor) and *healthy days*, which is the mean number of self-reported healthy days for physical and mental health during the past 30 days. For each of these two outcomes, four different measures of health equity are assessed: (1) *Black-White disparity*: mean difference in the health outcome between White and Black individuals; (2) *income disparity*: mean difference in the health outcome between top, middle, and bottom income categories; (3) *health justice*: variation in health outcome that is not explained by sex, income, or race/ethnicity; and (4) a summary health equity measure that is the mean weighted departure of individual health from best achievable health. The summary health equity measure is the only one of the three that combines information across the self-reported–health and healthy days outcomes. This summary measure is weighted such that larger departures from the best achievable health are weighted more heavily than smaller departures, and best achievable health is defined as the average outcome of the most privileged identifiable group (White men in top income category). Each measure is calculated for the nation overall, as well as for each state and year combination for which data were available. This approach provides information about trends in health equity (across the four dimensions) over time.

⁴⁰ F. J. Zimmerman and N. W. Anderson, “Trends in Health Equity in the United States by Race/Ethnicity, Sex, and Income, 1993–2017,” *JAMA Network Open*, Vol. 2, No. 6, 2019, pp. e196386.

4. Summary of Identified Health Equity Measurement Approaches

Table 4.1 summarizes the ten approaches that were identified. Some of the identified approaches focused primarily on determining which existing quality measures are suitable for health equity comparisons (i.e., permit reliable and valid comparisons among social risk factor groups) or for measuring organizational structures, systems, and processes hypothesized to promote the delivery of high-quality care for all. Other approaches focused primarily on making measure-by-measure comparisons, either making comparisons between providers in how they stack up against a higher-level standard or making comparisons within a provider or other reporting unit. Finally, some of the identified approaches focused on developing a system for combining different dimensions of health equity into a single summary index. Table 4.1 identifies the primary focus of each measure and further characterizes measures within those three primary categories.

The Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards (HHS OMH) and the NQF Disparities-Sensitive Measure Assessment both identified existing measures of processes for improving health equity, including organizational structures, systems, and processes that are hypothesized to promote the delivery of equitable care. The underlying assumption of these approaches is that such measures provide an assessment of how committed health care organizations are to the goal of providing equitable care and how equipped they are to meet the needs of a culturally and demographically diverse mix of patients. As mentioned above, our literature review identified several other articles and reports that similarly described such measures. Because there was a large degree of overlap among the specific measures identified in these articles and reports, we decided to bring only these two reports to the TEP for their evaluation, in the interest of expediency. The HHS OMH approach was the most recent and comprehensive of the articles and reports that we identified, and the NQF Disparities-Sensitive Measure Assessment identified additional categories of quality measures (e.g., preventive care, processes of care, and health outcome measures) above and beyond what fit under the CLAS rubric (and thus was of additional value).

Two approaches—the AHRQ National Healthcare Quality and Disparities Report and the CMS OMH MMD Tool—focused on making performance comparisons by social risk factor groups within a reporting unit on a measure-by-measure basis. In the case of the AHRQ National Disparities Report, the reporting unit is the nation, and the broad array of measures included access to care, processes of care, outcomes of care, and patient experiences of care (CAHPS). The AHRQ report focuses both on current cross-sectional performance and improvement in performance over time, using both statistical significance and magnitude criteria to identify meaningful differences in care across social risk factor groups. The CMS OMH MMD Tool focuses, one-by-one, on an even broader array of measures, all of which are derived from Medicare claims data and thus pertain to Medicare FFS only. The measures include chronic disease prevalence, health care utilization and spending, mortality rates, and patient safety measures but do not involve tests of statistical significance or magnitude criteria for identifying meaningful differences. The CMS OMH MMD Tool does, however, allow users to view disparities data at more granular levels of geography, including state and county levels.

CMS OMH reports scores from the CAHPS and HEDIS, stratified by race, ethnicity, and gender, and also provides two separate views of this information. One view facilitates comparisons of performance of MA and PDP contracts and states in the quality of care they provide to a particular racial or ethnic group or to rural or urban residents. The other view facilitates comparisons of performance within MA and PDP contracts and states in the quality of care provided to different racial and ethnic groups and in urban versus rural areas. In each case, the focus is on cross-sectional performance, comparisons are made measure-by-measure, and statistical comparisons to the national average for each social risk factor group are provided.

The *Minnesota Healthcare Disparities Report*, issued annually by Minnesota Community Measurement, presents data on a set of clinical process of care measures (HEDIS) stratified by race, ethnicity, preferred language, and country of origin. Stratified data are presented at the state level and at the medical group level. This approach, too, focuses on measure-by-measure comparisons. At the state level, scores for social risk factor groups are compared with each other and to overall statewide averages on each measure. The state-level reporting is similar to one of the options provided by the CMS OMH MMD Tool and to the CMS OMH stratified reporting of Medicare FFS data at the state level. At the medical group level, scores for social risk factor groups are compared with overall statewide averages and state averages specific to the social risk factor group. The medical group-level reporting is similar to the CMS OMH stratified reporting of MA and PDP performance data at the contract level, in that both present between- and within-provider comparisons. However, the data presented by the CMS OMH span the nation, whereas the data presented in the *Minnesota Healthcare Disparities Report* is limited to the state of Minnesota. Like the CMS OMH MMD Tool and the CMS OMH stratified reporting approach, the *Minnesota Healthcare Disparities Report* focuses on cross-sectional performance.

The CMS Assessment of Hospital Disparities for Dual-Eligible Patients focuses on a single social risk indicator, dual-eligibility status, and a single outcome measure, 30-day all-cause unplanned readmission following hospitalization for pneumonia, but the principles of this approach could be applied more broadly. Performance for dual-eligible patients is compared across hospitals using criteria of statistical significance and magnitude of differences. Performance is also compared within hospitals for dual-eligible and non-dual-eligible beneficiaries, again using criteria of statistical significance and magnitude of differences. This approach is one of only three identified approaches that include a magnitude criterion for distinguishing ten levels of performance. The other two approaches that use such a criterion are the *AHRQ National Disparities Report* and the CMS OMH HESS.

The CMS OMH HESS approach identified CAHPS and HEDIS measures suitable for health equity comparisons (based on criteria of reliability and reportability) and uses data on those measures to assess the extent to which care provided through MA contracts was equitable according to race and ethnicity and dual/LIS-eligibility status. This approach compares both cross-sectional performance and improvement in performance for racial and ethnic minority groups and for dual/LIS-eligible beneficiaries across contracts relative to national averages for each group. This approach also compares performance for different racial and ethnic groups and for dual/LIS eligible and noneligible beneficiaries within contracts. The HESS is one of three identified approaches that developed a system for combining different dimensions of health equity into a single equity measure (the other two being the approaches by Zimmerman and by Zimmerman and Anderson, described next). In particular, the HESS combines data across multiple measures, multiple social

risk factors, and across multiple types of comparisons, i.e., both within- and between-provider comparisons and comparisons focused on both cross-sectional performance and improvement in performance. Performance is summarized on a 1-to-5-star scale. A dashboard for presenting HESS data to MA contracts confidentially is under development. On that dashboard, contracts can drill down to see data for each measure and group to pinpoint their areas of strength and weakness.

Like the CMS OMH HESS, the Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity synthesizes information across more than one measure rather than examining the measures individually, as is done, e.g., in the AHRQ and CMS OMH stratified reporting approaches. Zimmerman's approach is oriented toward assessing the total deviation from a defined privileged group (high-income White males) and allows disaggregation from the national level to the level of states and smaller geographic areas. Although this approach—which focuses on cross-sectional performance only—implicitly describes being female, low-income, and non-White as risk factors, it does not allow for making distinctions among these groups, i.e., it treats them collectively as a singular disadvantaged group.

In part, the Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity is comparable to the approach taken in the *AHRQ National Disparities Report* to look at trends over time. It uses 25 years of Behavioral Risk Factor Surveillance System data to examine trends in health disparities by race (Black versus White individuals) and income and uses statistical tests of trend information to characterize disparities in self-rated health and healthy days in the past month as either decreasing, increasing, or not changing (no trend identified). The Zimmerman and Anderson approach is also similar to the Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity and the CMS OMH HESS, in that it combines information on multiple measures and summarizes information on equity across social risk factors (race and ethnicity, sex, and income).

Table 4.1. Summary of Identified Approaches to Health Equity Measurement

	Approach (see key below)									
	1	2	3	4	5	6	7	8	9	10
Approach focused primarily on measure identification	x	x								
Identified existing measures of processes for improving health equity	x	x								
Assessed suitability of existing quality measures for health equity comparisons		x			x					
Approach focused primarily on measure-by-measure comparisons			x	x	x	x	x			x
Made between-provider (or other reporting unit) comparisons					x	x	x	x	x	
Made within-provider (or other reporting unit) comparisons			x	x	x	x	x	x		x
Examined cross-sectional (point-in-time) performance			x	x	x	x	x	x	x	
Examined on improvement in performance			x					x		x
Included use of statistical tests of differences			x		x	x	x	x		
Included consideration of magnitude of differences			x				x	x		
Summary indices of health equity								x	x	x
Combined information on multiple measures								x	x	x
Combined information on multiple social risk factors								x	x	x
Combined information on multiple types of comparisons ^a								x		

^a For example, between- and within-unit comparisons or comparisons focused on cross-sectional performance and improvement in performance.

NOTES: **Approach 1** = Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards (HHS OMH); **Approach 2** = NQF Disparities-Sensitive Measure Assessment; **Approach 3** = AHRQ National Healthcare Quality and Disparities Report; **Approach 4** = CMS OMH Mapping Medicare Disparities Tool; **Approach 5** = CMS OMH Reporting of CAHPS and HEDIS Data by Race/Ethnicity for Medicare Beneficiaries; **Approach 6** = *Minnesota Healthcare Disparities Report*; **Approach 7** = CMS Assessment of Hospital Disparities for Dual-Eligible Patients; **Approach 8** = CMS OMH Health Equity Summary Score; **Approach 9** = Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity; **Approach 10** = Zimmerman and Anderson Approach to Evaluating Trends Over Time in Health Equity.

5. Technical Expert Panel Process and Members

The project team convened a TEP via videoconference to discuss the measurement of health disparities and health equity and incorporation of health equity measures or domains in Medicare VBP and quality reporting programs. RAND researchers constructed an initial list of potential panelists with expertise in social risk factors, health disparities, health equity, risk adjustment, value-based and alternative payment models, and Medicare's VBP programs. This initial list was founded on the team's knowledge of the field and a preliminary review of recent literature on the topics of health disparities and health equity measurement. A final list was constructed in consultation with ASPE. The final list consisted of eight first-choice experts and eight alternates. All eight first-choice experts agreed to participate on the panel. Biographical information about each of the expert panelists is provided in Appendix C.

The project team developed a TEP notebook, which was shared with panelists five days prior to the first of two meetings held eight days apart. The notebook consisted of a TEP charter; biographies of the participating panelists; project background, objectives, and methods used to identify health equity measures and approaches; descriptions of each of the ten approaches to health equity measurement that were identified via the literature review; and preliminary criteria for evaluating those approaches. The team also distributed rating sheets to facilitate the assessment of each approach according to the rating criteria and to solicit additional commentary from the panelists.

During the initial meeting, the TEP was asked to provide feedback on the team's proposed definition of a health equity measure and categorization of features of health equity measures. At that initial meeting, the panel was also tasked with coming to a consensus on a final set of criteria for evaluating the identified approaches to health equity measurement and to begin discussing the identified approaches. Approaches that were not discussed at the initial meeting were discussed at the second meeting. To facilitate the discussion, the team presented an overview of each approach and invited the TEP members to engage in a focused discussion following each overview. Each meeting lasted two hours. A project team member took notes during the discussion, and the meetings were audio recorded for additional notetaking afterward.

The team updated the rating criteria in response to the feedback given during the initial meeting and distributed the revised rating sheet directly following the first meeting. TEP members submitted their ratings for all ten approaches to health equity measurement using the updated rating criteria within ten days of the second meeting. The team drew on the input provided by the TEP via the rating sheets, verbal comments made during the meetings, comments submitted using the teleconferencing platform's chat function, and email messages sent after the meetings to provide the following assessment.

6. TEP Input on Project Framing and Approach

Input on Definition of a Health Equity Measurement Approach

TEP members pointed out that membership in defined “at-risk” groups is often not a direct mechanism for risk of receiving poor quality care but a proxy for more direct risk factors, such as food insecurity and homelessness. The group acknowledged, however, that researchers tend to rely on group membership as a proxy for direct mechanisms when constructing equity measures or assessing disparities because data on direct mechanisms is often unavailable. Moreover, members of some “at-risk” groups—e.g., racial and ethnic minorities—are especially likely to experience discrimination and other inequities based on group membership; in such instances, group membership on its own is a direct mechanism of interest. Nevertheless, the TEP emphasized the importance of encouraging organizations to collect additional data about risk factors rather than relying solely on data about group membership to assess equity and identify targets for improvement.

Relatedly, the TEP counseled that a measure of health equity should not be limited to comparing quality of care provided to groups predetermined to be disadvantaged, e.g., racial and ethnic minority patients to a reference group that is predetermined to be advantaged, e.g., White patients. Keeping with the racial/ethnic example, one issue is that White patients may not be the group for which performance is highest on a measure. Even if White patients are the group for which performance is highest on a measure, they may still be getting suboptimal care. In either case, using care received by White patients as the benchmark for racial and ethnic minority patients would not encourage the highest-quality care possible for racial and ethnic minority patients. Moreover, the practice of defining and comparing to a *reference* group may imply a standard for *nonreference* groups, suggest that those groups are nonnormative, and promote a need for assimilation and acculturation.

Rather than using the quality of care provided to one prespecified group as the benchmark for other groups, the TEP advocated adopting a framework for equity that focuses on making sure that all groups and people are provided with the care and resources they need to achieve optimal health. In practice, this could mean comparing all other groups with the highest-performing group, regardless of whether the highest-performing group is nominally “at risk,” comparing all groups to an overall state or national average, or adopting an approach that focuses on improvement rather than on point-in-time performance for a group. The TEP also emphasized that achieving high-quality care for all groups requires aligning care and resources with patient needs and preferences to optimize their health rather than defining outcomes based on a predetermined reference group that has certain advantages along one or more dimensions. Furthermore, the TEP encouraged adopting a framework for equity that sets a universal target of excellent care for all groups and all people but that recognizes that the best care for a given group or person may require tailoring and customization of care.

This view of health equity as maximizing opportunities for all to be healthy is reflected in the philosophy of the Robert Wood Johnson Foundation’s Health Opportunity and Equity (HOPE)

Initiative.⁴¹ The HOPE Initiative tracks social and economic factors, community and safety factors, physical environment factors, access to health care, and a limited set of health outcomes (infant mortality, low birthweight, premature mortality, and self-rated health) by race and ethnicity and socioeconomic status for tracking progress toward health equity at the state and national level. Although this framework does not fit with the definition of a health equity measurement approach developed for this project, it is one that merits future consideration for its applicability to the assessment of health care organizations.

Input on Premise of the Project

TEP members also felt it was important for the research team to acknowledge that there is currently little empirical evidence that pay-for-performance and quality reporting strategies translate into reduction of disparities. Thus, if CMS were to incorporate one or more of the health equity measurement approaches identified by this project in a VBP or reporting program, it would be important to evaluate the impact on health equity so that this evidence base can be established. TEP members also advised that careful consideration should be given to the way payment is tied to performance on health equity measures. Consistent with our definition of a health equity measurement approach, TEP members felt that payment on the equitable delivery of care should be reserved for the purpose of improving care for at-risk populations and that the number of high-risk patients that an organization serves should be considered as part of any payment scheme, as this partly determines the magnitude of an organization's contribution to health equity nationally.

Input on Evaluation Criteria

The research team developed a preliminary set of criteria for evaluating the health equity measurement approaches identified by the literature review. The TEP provided input on those criteria during the first TEP meeting. The revised set of criteria, which incorporates the TEP's feedback, is shown in Table 6.1.

The criterion that social risk factor groups be measured at the most granular level possible did not appear in the preliminary set developed by the research team. This criterion was discussed in the context of race and ethnicity, with TEP members emphasizing the importance of characterizing the needs of smaller groups when possible and distinguishing the needs of subgroups who are sometimes combined to boost sample sizes, e.g., Asians and Pacific Islanders. TEP members acknowledged that most organizations are unlikely to have the sample sizes required for stable, meaningful measurement of small groups but that developers of health equity measurement approaches should at least attempt measurement of care for small groups (perhaps by pooling data across years or reporting units) and report on any trade-offs involved in doing so. The TEP also emphasized the importance of having accurate data on patient race and ethnicity. Self-report is the gold standard for collecting data on race and ethnicity,⁴² but the process for eliciting information

⁴¹ Robert Wood Johnson Foundation, "Measures to Advance Health and Opportunity," HOPE Initiative homepage, undated. As of January 7, 2021: <https://www.hopeinitiative.org/>

⁴² D. J. Klein, M. N. Elliott, A. M. Haviland, P. A. Morrison, N. Orr, S. Gaillot, and R. Weech-Maldonado, "A Comparison of Methods for Classifying and Modeling Respondents Who Endorse Multiple Racial/Ethnic Categories," *Medical Care*, Vol. 57, 2019, pp. e34–e41.

about race and ethnicity in a way that best captures how Medicare beneficiaries identify themselves has evolved over time and will require continued attention to keep pace with demographic and cultural trends in the United States.⁴³ Another criterion that did not appear in the preliminary set is the one pertaining to the likely impact of adopting an approach into a Medicare VBP or reporting program on how equitably organizations provide care to their patients. The TEP felt that it was important to add such an overall evaluation of whether implementing an approach in its currently specified form would help achieve the goal of health equity.

⁴³ U.S. Census Bureau, “Research to Improve Data on Race and Ethnicity,” webpage, U.S. Department of Commerce, 2017. As of January 7, 2021: <https://www.census.gov/about/our-research/race-ethnicity.html>

List 6.1. Revised Criteria for Evaluating Health Equity Measurement Approaches

Evidence-based

Is the approach based on available evidence of the relationship between the social risk factor and outcome?

Usability

Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?

Does the approach guard against unintended consequences of worsening quality or access or disincentivizing resources for any beneficiaries?

Measurement Equivalence

Is the approach appropriate for use with all social risk factor groups, or is it applicable only to certain groups?

Breadth of Applicability

Is the approach suitable only to a specific VBP or quality reporting program, or can it be more to multiple providers and settings?

Reliability

Is the approach able to distinguish performance between providers/programs?

Does the approach capture granular subgroups where possible while limiting the influence of imprecise estimates?

Impact

How likely is it that incorporating this measure or approach in a VBP or quality reporting program would result in a noticeable improvement in health equity?

7. Detailed Assessment of Identified Approaches

Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards

TEP members' ratings of this approach are shown in Table 7.1. A majority of members (five) fully agreed that this approach is evidence-based, and all either fully or partially agreed that the approach is designed to incentivize achievement or improvement for at-risk beneficiaries. Members were divided in their assessment of whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries and whether the approach is able to reliably distinguish performance among providers; in each case, four members said that the approach either fully or partially meets the criterion, three said that there is not enough information to tell, and one member said that the approach does not meet the criterion. Most members (five) said that the approach is applicable to particular groups, several specifically highlighting applicability to people with limited English proficiency and racial and ethnic minority groups. Four of seven members⁴⁴ said that the approach is applicable to multiple VBP or reporting programs. A majority of members (five) felt that incorporation of the approach in a VBP or reporting program would somewhat or very likely result in a noticeable improvement in health equity.

In discussing this approach, TEP members pointed out that much is still unknown about the structures, processes, and systems that are necessary to foster health equity. One member referenced a study by Blustein and colleagues⁴⁵ that demonstrated that a hospital could perform well on structural measures thought to facilitate high-quality care for racial and ethnic minority patients but not make a significant contribution to reducing racial and ethnic disparities in hospital care. Given such findings, TEP members felt that further evidence of the direct impact of constructs included in the National CLAS Standards on health equity would be needed before they could confidently say that incorporation of this approach into a VBP or reporting program would have the desired impact on health equity.

TEP members felt that some of the cross-cutting measures identified by Davis and colleagues would be more likely to foster health equity than others if tied to an incentive scheme. For example, one member mentioned that the CAHPS Cultural Competence Item Set, the CAHPS Item Set for Addressing Health Literacy, and a measure of the percentage of patients with limited English proficiency who get appropriate linguistic support are valuable in that they measure the desired outcome—provision of culturally and linguistically appropriate services—directly. On the contrary, some members felt that process measures, such as screening for and recording cultural and language issues, are less useful in that the absence of such documentation does not mean that

⁴⁴ One member did not complete this rating for this measurement approach. Two members did not complete the rating of whether this approach captures granular subgroups where possible. Otherwise, all eight members completed every rating for every approach.

⁴⁵ J. Blustein, J. S. Weissman, A. M. Ryan, T. Doran, and R. Hasnain-Wynia, "Performance in Medicaid Can Efficiently Reduce Racial and Ethnic Disparities," *Health Affairs*, Vol. 30, No. 6, 2011, pp. 1165–1175.

services were not provided, and the presence of such documentation does not necessarily mean that patients got more appropriate care. This is not to say that these measures are not valuable, just that they should not be used as proxies for the quality of care that is delivered.

Another disadvantage of this approach identified by one TEP member is that it does not recognize or reward the ability of an organization to address patient needs by financial situation or, more generally, by social class. Finally, one member felt that collection of the data needed for this approach would be “exceedingly burdensome” for organizations, particularly given that the impact of assessing adherence to CLAS standards is still largely unknown.

Table 7.1. TEP Ratings of Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	5	2		1
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	3	5		
Does the approach guard against unintended consequences for at-risk beneficiaries?	2	2	1	4
Is the approach able to reliably distinguish performance between providers?	2	2	1	3
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		5	2	1
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		4		3
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?			1	5
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	4	1	2

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

NQF Disparities-Sensitive Measure Assessment

TEP members' ratings of this approach are shown in Table 7.2. Nearly all members (seven) fully agreed that this approach is evidence-based, and nearly all (seven) either fully or partially agreed that the approach is designed to incentivize achievement or improvement for at-risk beneficiaries. Members were divided in their assessment of whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with four members saying that there is not enough information to tell, and four saying that the approach either fully or partially fulfills this criterion. A majority of members (five) fully or partially agreed that the approach is able to reliably distinguish performance among providers. A majority (five) also said the approach is applicable to particular groups, sometimes noting a particular focus on racial and ethnic minority groups, and that the approach is applicable to multiple VBP or reporting programs. Nearly all members (seven) felt that incorporation of the approach in a VBP or reporting program would somewhat or very likely result in a noticeable improvement in health equity.

In commenting on this approach, most TEP members felt that its principal advantage is in the way that it formally and rigorously vetted a large group of measures for possible inclusion in a stratified reporting scheme or other approach to health equity measurement. Many also emphasized the advantage of the measures being NQF-endorsed, and several highlighted that some of the measures are based on claims data, which alleviates data collection burden. Most members commented that the usability, applicability, and reliability of the approach would depend on how the disparities-sensitive measures were used in a health equity metric or reporting program. Even so, nearly all felt that incorporating measures determined to be disparities-sensitive into a more complete approach to health equity measurement could have a noticeable impact on health equity, particularly if rewards are focused on improvements for at-risk populations toward feasible and desired benchmarks.

Table 7.2. TEP Ratings of NQF Disparities-Sensitive Measure Assessment

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	7	1		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	4	3		1
Does the approach guard against unintended consequences for at-risk beneficiaries?	2	2		4
Is the approach able to reliably distinguish performance between providers?	4	1	1	1
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		5	3	
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		5		3
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		4	1	1
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	6	1	

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

AHRQ National Healthcare Quality and Disparities Report

TEP members' ratings of this approach are shown in Table 7.3. Nearly all members (seven) fully agreed that this approach is evidence-based, but there was considerable uncertainty about whether the approach is designed to incentivize achievement or improvement for at-risk beneficiaries. There was also considerable uncertainty about whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with five members saying that there is not enough information to tell and two saying that the approach does not meet this criterion. Only two members fully or partially agreed that the approach is able to reliably distinguish performance among providers—one member commented that there is likely too little data to make this approach feasible at the level of individual providers—but a majority (five) said the approach is applicable to all social risk factor groups. Six members said that the applicability to VBP or reporting programs is uncertain. Members were divided about whether incorporation of the approach in a VBP or reporting program would result in a noticeable improvement in health equity; five said that such an outcome would be somewhat likely, one said that it would be somewhat unlikely, and two said that it would be very unlikely.

Some TEP members commented that the major limitation of this approach is the heterogeneity of the measures included and their selection based on availability in federal data sets. It was noted that some of the measures are relevant only at the population level but that many are applicable to hospitals, plans, and other health care organizations, and thus are potentially useful for one or more Medicare VBP and quality reporting programs. However, the majority opinion was that additional work would be needed to determine exactly how this approach could be operationalized at these finer levels of analysis. One member commented that although the analytic methods are robust, the approach does not appear applicable to the task of comparing provider performance or showing providers their performance relative to peers or benchmarks. Several members questioned the appropriateness of comparing groups of patients to predefined reference groups and pointed out that catching disadvantaged patients up to a predefined reference group is only a small part of achieving health equity. One member expressed a strong preference for an approach that rewards any meaningful improvement for a high-risk group, stating that, absent such a criterion, providers could be rewarded for providing substandard care to all groups equally or worsening care for leading groups. Some also expressed concerns about the degree of risk adjustment involved in this approach, with a couple commenting that some measures used in this approach could be heavily influenced by social factors for which adjustments are not currently being made.

Table 7.3. TEP Ratings of *AHRQ National Healthcare Quality and Disparities Report*

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	7	1		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	2	2	2	2
Does the approach guard against unintended consequences for at-risk beneficiaries?	1		2	5
Is the approach able to reliably distinguish performance between providers?	1	1	3	3
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		2	5	1
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		2		6
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		5	1	2
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?		5	1	2

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

CMS OMH Mapping Medicare Disparities Tool

TEP members' ratings of this approach are shown in Table 7.4. A majority of members (five) fully agreed that this approach is evidence-based, but there was considerable uncertainty about whether the approach is designed to incentivize achievement or improvement for at-risk beneficiaries, with three members saying that the approach does not meet this criterion. There was also considerable uncertainty about whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with three saying that the approach does not meet this criterion, two saying that it partially meets this criterion, and three saying that there is not enough information to tell. A majority of members (five) said that the approach is unable to reliably distinguish performance among providers. Most members (five) saw the approach as being applicable to particular social risk factor groups, but some (three members) saw it as more broadly applicable. Members were divided in their opinion of the applicability to VBP or reporting programs, with three saying that it is applicable to multiple programs, three saying that there is not enough information to decide, and two saying that it is applicable to one program only (without specifying which program). Six members said that this approach would be either somewhat or very unlikely to result in a noticeable improvement in health equity if incorporated into a VBP or reporting program.

Several TEP members commented that this approach is not likely to incentivize achievement or improvement for at-risk beneficiaries as it is currently designed, citing both its descriptive purpose (i.e., lack of statistical comparisons) and focus on comparing performance across geographic areas rather than providers. The majority opinion was that significant work would need to be done to convert the approach into an equity quality metric and that issues of risk adjustment (beyond age), sample size, and ability to reliably discriminate performance across providers would need to be addressed. One member commented that exclusion of the MA population, due to lack of necessary data, is a significant limitation of the tool. During the discussion, it was noted that CMS is considering incorporating other programs' data sources into the MMD Tool, which would increase the scope but not address the main limitations of the tool as seen by the TEP.

Table 7.4. TEP Ratings of CMS OMH Mapping Medicare Disparities Tool

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	5	2		1
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	1	3	3	1
Does the approach guard against unintended consequences for at-risk beneficiaries?		2	3	3
Is the approach able to reliably distinguish performance between providers?	1	1	5	1
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		5	3	
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program or can it be applied more broadly?		3	2	3
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		2	3	3
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?		2	3	3

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

CMS OMH Reporting of CAHPS and HEDIS Data, Stratified by Race and Ethnicity, for Medicare Beneficiaries

TEP members' ratings of this approach are shown in Table 7.5. Six members fully agreed that this approach is evidence-based, while two said that it partially meets this criterion. Nearly all (seven) either fully or partially agreed that the approach is designed to incentivize achievement or improvement for at-risk beneficiaries. There was, however, considerable uncertainty about whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with four members saying that there is not enough information to decide and two saying that the approach does not meet this criterion. Six members either fully or partially agreed that the approach is able to reliably distinguish performance among providers. Four members said the approach is applicable to all social risk factor groups, and half said it is applicable to particular groups. Six members said that the approach is applicable to multiple VBP or reporting programs, while two said that there is not enough information to decide. A majority of members (five) said that this approach would be either somewhat or very likely to result in a noticeable improvement in health equity if incorporated into a VBP or reporting program, but two members said that it would be very unlikely to have such an effect.

One TEP member commented that this was among the stronger approaches in the set identified, and another said that this was the most robust approach in attending to adequacy of sample size and reliability of scores for making between-provider comparisons. One member commented that, in its current form, this approach is best suited for incentivizing improvement via public reporting (its current use) and that additional risk adjustment might be needed before payment could be fairly tied to performance. A couple of members pointed out that some of the measures used in this approach are collected via survey and mentioned that there are limitations to this mode of data collection, e.g., low response rates and sample sizes and the possibility of recall bias. Relatedly, a couple of members suggested that this approach could be improved by incorporating outcome measures, e.g., by supplementing the current set of measures with encounter data. Several members observed that many MA and PDP contracts are unmeasurable for at least some racial and ethnic minority groups and measures. One member suggested that more years of data could be pooled to gain insight into performance for smaller populations, such as American Indians and Alaska Natives and Asian and Latino subgroups.

Table 7.5. TEP Ratings of CMS OMH Reporting of CAHPS and HEDIS Data Stratified by Race and Ethnicity for Medicare Beneficiaries

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	6	2		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	4	3		1
Does the approach guard against unintended consequences for at-risk beneficiaries?		2	2	4
Is the approach able to reliably distinguish performance between providers?	4	2	1	1
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		4	4	
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		6		2
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		3	3	2
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	4	1	2

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

Minnesota Healthcare Disparities Report

TEP members' ratings of this approach are shown in Table 7.6. Six members fully agreed that this approach is evidence-based, while two said that it partially meets this criterion. Nearly all (seven) fully agreed that the approach is designed to incentivize achievement or improvement for at-risk beneficiaries. A majority (five) felt that there was not enough information to determine whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, though three members said that the approach either fully or partially meets this criterion. Six members either fully or partially agreed that the approach is able to reliably distinguish performance among providers. A majority of members (five) said the approach is applicable to particular social risk factor groups, and the remainder said it is applicable to all groups. Nearly all (seven) said that the approach is applicable to multiple VBP or reporting programs. All members said that this approach would be either somewhat or very likely to result in a noticeable improvement in health equity if incorporated into a VBP or reporting program.

Several members commented that this approach uses a thoughtfully chosen group of measures focused on processes and outcomes of care for specific, common conditions. One member highlighted the focus on disparities by language and country of origin as a particularly strong feature. Two members commented that some of the measures could be strongly influenced by social determinants of health and that there should be further consideration given to risk adjustment; although this concern was raised in the context of this approach, it may be applicable to other approaches involving similar measures. Three members expressed concern that insufficient attention had been given to the sample size required for reliable provider-based measurement and that each measure should have undergone testing to determine the sample size needed for reliability of 0.70 or higher. Most members, though, felt that this approach was a strong building block for a more broadly applicable approach, with one member commenting specifically about the benefit of anchoring disparities to the overall state average rather than the performance of a predetermined group.

Table 7.6. TEP Ratings of Minnesota Healthcare Disparities Report

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	6	2		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	7	1		
Does the approach guard against unintended consequences for at-risk beneficiaries?	1	2		5
Is the approach able to reliably distinguish performance between providers?	1	5	1	1
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		5	3	
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		7		1
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		3	1	4
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	7		

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

CMS Assessment of Hospital Disparities for Dual-Eligible Patients

TEP members' ratings of this approach are shown in Table 7.7. All members either fully or partially agreed that this approach is evidence-based and that it is designed to incentivize achievement or improvement for at-risk beneficiaries. Members were divided about whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with four saying that it fully or partially meets this criterion, two saying that it does not meet this criterion, and two saying that there is not enough information to judge. Nearly all (seven) either fully or partially agreed that the approach is able to reliably distinguish performance among providers. Four members said the approach is applicable to all social risk factor groups, while three said it is applicable to particular groups (citing dual-eligible beneficiaries as the applicable group). Four members felt that the approach is applicable to multiple VBP or reporting programs, while three members felt that it was applicable to one program only. Members were divided in their judgment of the likelihood that this approach would result in a noticeable improvement in health equity if incorporated into a VBP or reporting program: One member said that such a result is very likely, four said somewhat likely, and three said somewhat unlikely.

A couple of TEP members commented about the narrowness of this assessment, but both conceded that the approach seems broadly applicable to social risk factor groups and measures and so could be extended in those ways to increase impact. It was also noted that the within-hospital component of this approach does not distinguish the direction of differences. This could create a scenario in which worsening care for dual-eligible patients (or other at-risk patients if this approach were to be extended to other groups) results in a higher score on the measure (and an incentive if the approach were linked to an incentive scheme). A couple of TEP members also commented that there is insufficient evidence that having just 12 patients in each group for a within-plan comparison can result in a meaningfully informative estimate. One member commented that with such small samples, even large inequities are likely to lead to a null finding, which is potentially misleading. Finally, almost all TEP members preferred an approach in which additional casemix adjustment for contextual factors such as housing and food instability were incorporated.

Table 7.7. TEP Ratings of CMS Assessment of Hospital Disparities for Dual-Eligible Patients

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	6	2		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	5	3		
Does the approach guard against unintended consequences for at-risk beneficiaries?	3	1	2	2
Is the approach able to reliably distinguish performance between providers?	1	6		1
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		3	4	1
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		4	3	1
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		1	3	4
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	4	3	

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

CMS OMH Health Equity Summary Score

TEP members' ratings of this approach are shown in Table 7.8. Nearly all members (seven) fully agreed that this approach is evidence-based and that it is designed to incentivize achievement or improvement for at-risk beneficiaries. Nearly all (seven) either fully or partially agreed that the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with one member specifically commenting that the HESS is built to incentivize rather than penalize providers. Again, nearly all members (seven) fully agreed that the approach is able to reliably distinguish performance among providers. Four members said the approach is applicable to particular social risk factor groups, and four said it is applicable to all groups, with one member commenting that the HESS was explicitly designed to be able to add other social risk factors as more information about their relationship to quality becomes available. Nearly all members (seven) said that the approach is applicable to multiple VBP or reporting programs. All members said that this approach would be either somewhat or very likely to result in a noticeable improvement in health equity if incorporated into a VBP or reporting program.

Two members commented that, unlike other measures, the HESS is precisely suited for inclusion in VBP programs, increasing the likelihood that it would have an impact on equity. Three members specifically commented that it is among the better approaches identified, particularly given its joint consideration of cross-sectional performance and improvement in performance. One member highlighted its focus on patient experience and clinical quality measures as a positive feature, another highlighted its careful attention to reliability and the sample size required to achieve it (though one member commented that the strict reliability standards might not allow for including small subgroups in reporting), and yet another commented that data collection burden is not an issue because this is a secondary use of the data summarized by the metric. The consensus opinion was that this is a sound summary measure of health equity that produces information that is actionable and important.

Table 7.8. TEP Ratings of CMS OMH Health Equity Summary Score

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	7	1		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	7	1		
Does the approach guard against unintended consequences for at-risk beneficiaries?	3	4		1
Is the approach able to reliably distinguish performance between providers?	7	1		
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		4	4	
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		7		1
		Yes	No	Not enough information to determine
Does the approach capture granular subgroups where possible?		3	2	3
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	2	6		

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity

TEP members' ratings of this approach are shown in Table 7.9. All members either fully or partially agreed that this approach is evidence-based. Members were divided about whether the approach is designed to incentivize achievement or improvement for at-risk beneficiaries, with four saying that it fully or partially meets this criterion, two saying that it does not meet this criterion, and two saying that there is not enough information to judge. Four members said that this approach does not guard against unintended consequences of worsening access or resources for at-risk beneficiaries, and three said that there is not enough information to make this determination. Four members said that the approach is not able to reliably distinguish performance among providers, and two said that there is not enough information to make this determination. A majority of members (five) said the approach is applicable to all social risk factor groups, while two said it is applicable to particular groups. Though two members said that the approach is applicable to multiple VBP or reporting programs, six said there was not enough information to make this determination. A majority of members (five) said that it was somewhat or very unlikely that this approach would result in a noticeable improvement in health equity if incorporated into a VBP or reporting program.

The consensus opinion was that this is an interesting approach for describing full population equity issues, but a lot of work would be required to adapt this approach for incorporation into a VBP or quality reporting program, and there are potential barriers to making such an adaptation. Several members raised concerns about the measures that are summarized by this approach, citing evidence that different racial and ethnic groups use the self-rated health scale differently and that some minority groups have lower expectations about overall health. Members also raised concerns about the use of White men as the reference group. Although White men are a standard for privilege, they do not represent optimal health on many measures. Using White men as the reference group for calculating this measure thus sets a low bar for assessing equity. A couple of TEP members pointed out that the approach depends on collecting or having available the Behavioral Risk Factor Surveillance Survey measures on which the measure is based and that there would be significant logistical challenges to ensuring consistent data quality and completeness if one were to collect these data from patients or plan members. A couple of members also commented that the required sample size for making accurate comparisons using this approach is unknown, as is the time frame in which one might expect meaningful changes in this score as a result of organizational changes. Finally, one member pointed out that there is a potentially serious patient-mix issue to address, in that an organization could score well on this metric simply by serving a large proportion of patients who are counted among the disadvantaged but for whom disparities relative to high-income White males are small.

Table 7.9. TEP Ratings of Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	6	2		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	2	2	2	2
Does the approach guard against unintended consequences for at-risk beneficiaries?	1		4	3
Is the approach able to reliably distinguish performance between providers?	2		4	2
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		2	5	1
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		2		6
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		3	2	3
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	2	3	2

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity

TEP members' ratings of this approach are shown in Table 7.10. All members either fully or partially agreed that this approach is evidence-based. Members were divided about whether the approach is designed to incentivize achievement or improvement for at-risk beneficiaries, with four saying that it fully or partially meets this criterion, two saying that it does not meet this criterion, and two saying that there is not enough information to judge. Four members said that there was not enough information to determine whether this approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, and two said that the approach does not satisfy this criterion. The majority of members (five) said either that the approach is unable to distinguish performance among providers or that there is not enough information to tell. Members were divided about the applicability of this approach to different social risk factor groups, with two saying that it is appropriate for particular groups, three saying that it is appropriate to all groups, and three saying that there is not enough information to tell. Though two members said that the approach is applicable to multiple VBP or reporting programs, six said there was not enough information to make this determination. A majority of members (five) said that it was somewhat or very unlikely that this approach would result in a noticeable improvement in health equity if incorporated into a VBP or reporting program.

All of the same critiques that were applied to the Zimmerman (2019) approach were raised about this approach. One member commented that the focus on change over time is advantageous in that it provides potential to reward an organization for improving the health of a currently disadvantaged group. One member commented that the distinction made between health disparities, inequality, and justice is unusual and unhelpful, while another commented that a measure that simply compares care for Black and White patients is limited in that it pegs the care of Black patients to that of White patients.

Table 7.10. TEP Ratings of Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	5	3		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	2	2	2	2
Does the approach guard against unintended consequences for at-risk beneficiaries?	1	1	2	4
Is the approach able to reliably distinguish performance between providers?	1	1	3	3
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		2	3	3
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		2		6
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		1	3	4
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	2	2	3

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

8. Summary and Key Takeaways

Summary

The objectives of this project were to search for existing health equity measurement approaches and consider their suitability for inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports as a way to incentivize health equity. A formal **definition of a health equity measurement approach** was developed to guide the search: an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients.

Ten such approaches were identified and evaluated by a panel of experts on social risk factors, health disparities, health equity, risk adjustment, value-based and alternative payment models, and Medicare's VBP programs. These ten approaches, which generated varying levels of enthusiasm among the panel, fit within **three broad categories of approaches**: (1) approaches focused on determining which existing quality measures are suitable for health equity comparisons (i.e., permit reliable and valid comparisons among social risk factor groups) or for measuring organizational structures, systems, and processes hypothesized to promote the delivery of high-quality care for all; (2) approaches that engaged in particular kinds of comparisons of measures (not necessarily statistical comparisons), on a measure-by-measure basis, between groups of patients with greater versus lesser social risk factor burden; and (3) approaches that developed a system for combining different dimensions of health equity into a single summary index.

This project also identified a set of guidelines for health equity measurement. A health equity measurement approach should, ideally,

- be based on measures on which disparities in care are known to exist for certain populations or that address health care disparities and culturally appropriate care
- reflect available evidence bearing on the relationship between a social risk factor and health or health care outcome
- be designed to incentivize achievement or improvement for at-risk beneficiaries, including having a valid and appropriate benchmark and/or reference group if comparisons to benchmarks and/or reference groups are made
- include design features that guard against unintended consequences of worsening quality or access or disincentivizing resources for any beneficiaries, including the at-risk beneficiaries who are the focus of health equity measurement
- establish measurability requirements that ensure the ability to make reliable distinctions between health care providers in their performance in the domain of health equity
- capture information about small subgroups, where possible, while limiting the influence of imprecise estimates of provider performance.

In the case of a summary index, the measure should also

- summarize information in a way that is psychometrically sound
- allow for disaggregation of information to permit easy identification of quality improvement targets.

Key Takeaways

The ten approaches that the TEP evaluated were judged to meet these requirements to widely varying degrees. Of approaches focused on measure identification (Category 1), the **NQF Disparities-Sensitive Measure Assessment** was viewed most favorably by the TEP. Using a set of carefully established criteria and an easy-to-understand point system, this approach identified 32 NQF-endorsed measures as disparities-sensitive. Although considerable work would be needed to determine whether and how these measures could be linked to social risk data and whether and how valid comparisons could be made, this approach was viewed as a valuable initial step toward measuring health equity and disparities in health care quality. It is potentially applicable to any Medicare VBP or quality reporting program that collects one or more of the 32 disparities-sensitive measures. Furthermore, there may be the potential to enhance the favored approaches to be described next by incorporating one or more of the disparities-sensitive measures identified by this NQF approach.

Of approaches focused on measure-by-measure comparisons (Category 2), **the approach underlying the Minnesota Healthcare Disparities Report** was judged most favorably by the TEP. The perceived advantages of this approach include its thoughtfully chosen group of measures, incorporation of multiple important social risk factors, ability to reliably distinguish performance among providers, clear focus on incentivizing achievement for at-risk beneficiaries, and choice to anchor disparities to the overall state average rather than the performance of a predetermined group. Although some additional work would be needed to transfer this approach to a broader setting, including making careful considerations about sample sizes required for accurate comparisons and determining the availability of data on social risk factors, the method itself is readily applicable to all Medicare VBP and quality reporting programs.

Of approaches focused on summary indices (Category 3), the **CMS OMH HESS** was judged most favorably by the TEP. The perceived advantages of this approach include its joint consideration of cross-sectional performance and improvement in performance, focus on patient experience and clinical quality, careful attention to reliability and the sample size required to achieve it, direct applicability to certain VBP and quality reporting programs, and transferability to other programs. CMS OMH has designed a dashboard to provide confidential HESS data to MA contracts, though that dashboard has not yet been fully implemented. Scores on this metric could easily be incorporated into the Medicare Plan Finder and the MA Quality Star Ratings Program if doing so aligned with CMS's strategic priorities. This approach also could easily be extended to other social risk factors and measures, and there are plans to test the feasibility of extending this approach to settings beyond MA.

Of the ten approaches evaluated, the HESS received the highest ratings from the TEP overall. Given the high ratings it received, the HESS may be closest to meeting the full scope of goals outlined by ASPE for incorporating a measure of health equity into a Medicare VBP or quality reporting program. If HHS were to move forward with this approach, it could consider possible refinements to the approach based on the practices established by the NQF Disparities-Sensitive Measure Assessment and the *Minnesota Healthcare Disparities Report* and the guidelines for health equity measurement outlined by the TEP. Several of the measures that are included in the HESS are among the 76 measures identified as disparities-sensitive by NQF. It might be possible to include in the HESS additional measures from the set identified by NQF, provided that the measures are collected for MA plans and meet the reliability and sample size requirements established for the HESS. The

analyses that underlie the *Minnesota Disparities Report* are similar to the analyses that underlie the cross-sectional component of the HESS. In the Minnesota Healthcare Disparities Report, plan performance by patients' preferred language and country of origin are considered in addition to race and ethnicity. Information on country of origin is not available for Medicare Advantage beneficiaries, but information about Spanish preference is available. Thus, Spanish preference could be considered as a possible third social risk factor for the HESS.

Appendix A. Ambulatory, Hospital, Behavioral Health, and Public Health Measures Identified as Part of the Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards (HHS OMH)

Ambulatory Care Measures

CAHPS Cultural Competence Item Set

CAHPS Clinician/Group Survey

Disparities-Sensitive or CLAS-Salient Measures

- Controlling High Blood Pressure

- Hemoglobin A1c Poor Control

- Uncontrolled Diabetes Admission Rate

- Diabetes Short-Term Complications Admission Rate

Hospital Measures

Hospital CAHPS Survey

Hospital CAHPS Survey Health Literacy Item Set

Cultural Competency Assessment Tool for Hospitals

Joint Commission Standards for Hospital Accreditation and Elements of Performance

Joint Commission 2016 Measure List for Accreditation Chart-Abstracted Process Measures

Disparities-Sensitive or CLAS-Salient Measures

- 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization

- Median Time to ECG for Acute Myocardial Infarction or Chest Pain Patients

- 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Coronary Artery Bypass Graft Surgery

- Risk-Adjusted Deep Sternal Wound Infection

Behavioral Health Measures

Experience of Care and Health Outcomes (ECHO) Survey

Disparities-Sensitive or CLAS-Salient Measures

- Alcohol Screening and Follow-Up for People With Serious Mental Illness

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- Antidepressant Medication Management

30-Day All-cause Unplanned Readmission Following Psychiatric Hospitalization In An Inpatient Psychiatric Facility

Public Health Measures

Developing a Self-Assessment Tool for CLAS in Local Public Health Agencies

CAHPS Clinician/Group Survey

Disparities-Sensitive or CLAS-Salient Measures

Flu Vaccinations for Adults Ages 18 and Older

Asthma Emergency Department Visits

Depression Screening, Adolescents 18 Years of Age

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Appendix B. Measures Identified as Disparities-Sensitive According to the NQF Disparities-Sensitive Measure Assessment

Measures Identified Through First-Tier Review

Perinatal Care

- Exclusive Breast Milk Feeding
- Cesarean Section

Pediatric Care

- Developmental Screening by 2 Years of Age
- Children Who Received Preventive Dental Care
- Children Who Receive Family-Centered Care
- Children Who Receive Effective Care Coordination of Healthcare Services When Needed
- Children With Special Health Care Needs Who Receive Services Needed for Transition to Adult Care
- Children With Inconsistent Health Insurance Coverage in the Past 12 Months
- Children Who Have Inadequate Insurance Coverage for Optimal Health
- Children Who Attend Schools Perceived as Safe
- Children Who Live in Communities Perceived as Safe

Utilization/Appropriateness of Use

- Relative Resource Use for People with Asthma
- Relative Resource Use for People with COPD
- Relative Resource Use for People with Diabetes
- Relative Resource Use for People with Cardiovascular Conditions
- Asthma Emergency Department Visits
- Prostate Cancer: Avoidance of Overuse Measure—Bone Scan for Staging Low-Risk Patients

Screening and Prevention

- Cervical Cancer Screening
- Preventive Care and Screening: Body Mass Index Screening and Follow-Up
- Depression Screening by 13 Years of Age
- Depression Screening by 18 Years of Age
- Pneumonia Vaccination Status for Older Adults
- Pneumococcal Immunization (PPV 23)
- High Risk for Pneumococcal Disease—Pneumococcal Vaccination

Pneumococcal Vaccination of Nursing Home/Skilled Nursing Facility Residents
Pneumococcal Polysaccharide Vaccine Ever Received (Home Health)
Influenza Immunization: Outpatient
Influenza Immunization: Inpatient
Flu Shots for Adults Ages 50 and Over
Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents
Percentage of LTC Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine

Diabetes Care

Hemoglobin A1c Testing
Hemoglobin A1c Control (<8.0%)
Hemoglobin A1c Poor Control (>9.0%)
Diabetes and Elevated HbA1C—Use of Diabetes Medications
Adults Taking Insulin with Evidence of Self-Monitoring Blood Glucose Testing
Patients Who Had a Serum Creatinine in Past 12 Reported Months
Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Evaluation
Diabetic Foot Care and Patient Education Implemented
Diabetes Mellitus and Medication Possession Ratio for Chronic Medications

Cardiovascular Care

Controlling High Blood Pressure
Coronary Artery Disease and Medication Possession Ratio for Statin Therapy
Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
Median Time to ECG for Acute Myocardial Infarction (AMI) or Chest Pain Patients
Heart Failure: ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction
30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization for Adult Patients
Survival Predictor for Abdominal Aortic Aneurysm
Atrial Fibrillation—Warfarin Therapy
Deep Vein Thrombosis Anticoagulation \geq 3 Months
Adherence to Statin Treatment for Hyperlipidemia
Proportion of Patients with Hypercalcemia

Cancer Care

Oncology: Cancer Stage Documented
Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

Risk-Adjusted Morbidity and Mortality for Esophagectomy for Cancer

Multiple Myeloma—Treatment with Bisphosphonates

Hospice and Palliative Care

Proportion of Patients Who Died from Cancer Not Admitted to Hospice

Hospice and Palliative Care—Treatment Preferences

Hospice and Palliative Care—Pain Screening

Hospice and Palliative Care—Pain Assessment

Rehabilitation/Restorative Care

Physical Therapy or Rehabilitation/Restorative Care for Long-Stay Patients with New Balance Problem

Measures Identified Through Second-Tier Review (Communication/Care Coordination)

Clinician/Group Health Literacy Practices Based on CAHPS Item Set for Addressing Health Literacy

Clinician/Group's Cultural Competence Based on the CAHPS Cultural Competence Item Set

Patients Receiving Language Services Supported by Qualified Language Services Providers

Screening for Preferred Spoken Language for Health Care

Experience of Care and Health Outcomes (ECHO) Survey

Advance Care Plan

Reconciled Medication List Received by Discharged Patients

Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Proportion of Cancer Patients Admitted to the ICU in the Last 30 Days of Life

Percentage of Hospice Patients with Documentation of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Diabetes Short-Term Complications Admission Rate (PQI 1)

Diabetes Long-Term Complications Admission Rate (PQI 3)

Uncontrolled Diabetes Admission Rate (PQI 14)

Rate of Lower-Extremity Amputation Among Patients with Diabetes (PQI 16)

Appendix C. Biographical Information on Expert Panelists

Arlene Ash, Ph.D., is Professor and Division Chief of Biostatistics and Health Services Research in the Department of Population and Quantitative Health Sciences at the University of Massachusetts Medical School. She is an elected fellow of the American Statistical Association, the American Association for the Advancement of Science, and the International Statistical Institute. Dr. Ash pioneered tools for using administrative data to monitor and manage health care delivery systems, including those now widely used by the Medicare program and the Department of Health and Human Services. In 1996, she cofounded DxCG (now part of Cotiviti, Inc.) to promote “fair and efficient health care” through predictive software. In 2008, Dr. Ash’s risk-based predictive modeling work was honored by AcademyHealth with its Health Services Research Impact Award. Since 2014, she has worked with MassHealth (Massachusetts’ Medicaid and Children’s Health Insurance Program) to develop risk models that account for both medical and social risk factors when predicting health care utilization and costs. Her more than 200 research publications reflect long-standing interests in women’s health; gender, age and racial disparities; and quality, equity and efficiency in health care financing and delivery. She has also used her statistical expertise to advance gender equity in pay and to improve the integrity of U.S. elections.

Kevin Fiscella, MD, MPH, is Dean’s Professor of Family Medicine at the University of Rochester Medical Center. He has worked part-time in federally qualified health centers for more than 37 years as a family physician, addiction medicine physician, and Human Immunovirus physician. He is also a health services researcher with more than 250 peer-reviewed publications largely related to socioeconomic status, race, health, health care, and equity. Over the past decade, his research has focused on implementation research to identify pragmatic strategies for promoting health equity through randomized trials. Examples include community health workers for navigation of patients with cancer, practice-based outreach strategies to reduce disparities in cancer screening, use of electronic health record data for interventions and for primary outcomes assessment, peer-led patient activation trainings for low-income and minority people living with HIV, and use of academic detailing of clinicians and patient-centered peer coaching to promote uptake of atherosclerotic cardiovascular disease prevention among low-income and minority patients. Dr. Fiscella also has two decades of national committee experience related to measuring and reporting on health disparities and promotion of health, including two Institutes of Medicine committees, co-chairing two NQF advisory committees—measures for disparities/cultural and linguistic competency and SES-risk adjustment of quality measures. He currently represents the American Society of Addiction Medicine on the Board of the National Commission on Correctional Health Care (that accredits correctional health care), where he chairs the policy and research committee. He is a current member of the Disparities Monitoring Committee for NQF and a former member of the technical Advisory Panel on SES and Blood Pressure for the National Committee for Quality Assurance and former associate medical director for the local provider performance system for the New York State Delivery System Reform Incentive Program.

Darrell J. Gaskin, Ph.D., MS, is the William C. and Nancy F. Richardson Professor in Health Policy and Director of the Hopkins Center for Health Disparities Solutions at the Johns Hopkins Bloomberg School of Public Health in the Department of Health Policy and Management. Dr. Gaskin is a health

services researcher and health economist. He is an internationally recognized expert in health and health care disparities. He seeks to identify and understand place-based barriers to care for low-income, minority, and other vulnerable populations; to develop and promote policies and practices that address the social determinants of health to improve access to care, quality of care, and health care outcomes; and to promote equity in well-being, health, and health care by race, ethnicity, socioeconomic status, and geography. He serves on the Board of Scientific Counselors of the National Center for Health Statistics of the Centers for Disease Control and Prevention. He chairs the National Advisory Committee of the Robert Wood Johnson Foundation's System for Action program. Also, he serves on the Board of Directors of AcademyHealth and the American Society of Health Economists. He is a 2019 recipient of the Presidential Early Career Award for Scientists and Engineers. Dr. Gaskin has a Ph.D. in public health economics from the Johns Hopkins University. He holds an MS degree in economics from the Massachusetts Institute of Technology, and a BA degree in economics from Brandeis University.

Romana Hasnain-Wynia, MS, Ph.D., is the Chief Research Officer at Denver Health, where she oversees Denver Health's research and sponsored programs through the Office of Research and represents research interests as a member of the Executive Leadership Team. She also actively mentors junior investigators at Denver Health and the University of Colorado, Anschutz Medical Campus. Prior to joining Denver Health, Dr. Hasnain-Wynia served as the director of the Addressing Disparities program at the Patient Centered Outcomes Research Institute (PCORI), where she was responsible for providing strategic oversight and leadership for the program's funding priorities. Prior to PCORI, she was the director of the Center for Health Care Equity and Associate Professor at Northwestern University Feinberg School of Medicine. She spent a decade at the American Hospital Association's Health Research and Educational Trust, where she was Vice President of Research. She has been the principal investigator for a number of national studies focusing on advancing equity in health care with an emphasis on developing and integrating equity measurement in health systems. She uses mixed methods approaches in her research and has expertise in designing pragmatic trials in "real world settings." She is a member of NQF's Disparities Standing Committee and serves as the Chair of the Board for the Colorado Health Institute and is a member of the editorial boards of the journals *Health Affairs* and *Health Services Research*.

Sinsi Hernández-Cancio, JD, is a vice president at the National Partnership for Women and Families, where she leads the Health Justice team. She is a national health and health care equity policy and advocacy thought leader with 25 years of experience advancing equal opportunity for women and families of color, and almost 20 years advocating for increased health care access and improved quality of care for underserved communities. Sinsi is deeply committed to transforming our health care system to meet the needs of our rapidly evolving nation so we can all thrive together. She believes that our future prosperity depends on ensuring that our health care system routinely provides excellent, comprehensive, culturally centered, and affordable care for every single person, family, and community, and that this requires the dismantling of structural inequities including racism, sexism, ableism, homophobia, transphobia, xenophobia, and religious bigotry. Sinsi is a recognized leader in the national health equity movement, a sought-after strategic advisor, and a dynamic, inspiring speaker. She has presented at national events across the country and served on numerous advisory committees for organizations including the National Academy of Medicine, the National Committee for Quality Assurance, the Patient Centered Outcomes Research Institute, the Robert Wood Johnson Foundation, the National Center for Complex Health and Social Needs, and the American Association of Pediatrics. She has published extensively and has appeared

in national- and state-level English and Spanish television, radio, and print media. Her extensive experience in health and health equity policy and advocacy spans the state government, labor, and nonprofit arenas. Prior to joining the National Partnership's staff, she was the founding director of Families USA's Center on Health Equity Action for System Transformation, where she led efforts to advance health equity and reduce disparities in health outcomes and health care access and quality by leveraging health care and delivery system transformation to reduce persistent racial, ethnic, and geographic health inequities with an intersectional lens. Prior to that, she advised and represented two governors of Puerto Rico on federal health and human services policies, and she worked for the Service Employees International Union as a senior health policy analyst and national campaign coordinator for their Healthcare Equality Project campaign to enact the Affordable Care Act. She earned an AB from Princeton University's Woodrow Wilson School of Public and International Affairs and a JD from New York University School of Law, where she was an Arthur Garfield Hays Civil Liberties Fellow, and won the Georgetown Women's Law and Public Policy Fellowship.

Cara James, Ph.D., is President and CEO at Grantmakers In Health (GIH). Prior to joining GIH, she served as Director of the Office of Minority Health at CMS, where she provided leadership, vision, and direction to advance the HHS and CMS goals related to reducing disparities and achieving health equity for vulnerable populations, including racial and ethnic populations, persons with disabilities, sexual and gender minorities, and persons living in rural communities. Under her guidance, CMS developed its first CMS Equity Plan to Improve Quality in Medicare and its first Rural Health Strategy, created an ongoing initiative to help individuals understand their coverage and connect to care, increased the collection and reporting of demographic data, and developed numerous resources to help stakeholders in their efforts to reduce disparities. Before joining CMS, Dr. James served as Director of the Disparities Policy Project and Director of the Barbara Jordan Health Policy Scholars Program at the Henry J. Kaiser Family Foundation, where she was responsible for addressing a broad array of health and access to care issues for people of color and other underserved populations, including the potential impact of the Affordable Care Act, analyses of state-level disparities in health and access to care, and disparities in access to care among individuals living in health professional shortage areas. Prior to joining the foundation, she worked at Harvard University and the Picker Institute. Dr. James is a past member of the National Academies of Sciences, Engineering and Medicine's (NASEM) Health and Medicine Roundtable on the Promotion of Health Equity and has served on several NASEM committees. She has published a number of peer-reviewed articles. Dr. James holds her doctorate in health policy and her bachelor's degree in psychology from Harvard University.

Ninez Ponce, MPP, Ph.D. (BS University of California Berkeley; MPP Harvard; Ph.D. University of California Los Angeles [UCLA]), is Professor in the UCLA Fielding School of Public Health and Director of its Center for Health Policy Research. She leads the California Health Interview Survey (CHIS), the nation's largest state health survey, recognized as a national model for data collection on race/ethnicity, sexual orientation and gender identity, and immigrant health. She is a health services researcher most interested in reducing transaction costs levied on consumers and providers that produce racial/ethnic disparities. Her research on health disparities focuses on developing multicultural survey measures, implementing population-based health surveys in diverse populations, and examining the intersection of social factors and health policy. In 2019, Dr. Ponce and the CHIS team received the AcademyHealth Impact award for her contributions to population health measurement to inform public policies.

Dana Gelb Safran, Sc.D., was most recently Head of Measurement for Haven, the health care venture formed by Amazon, Berkshire Hathaway, and JPMorgan Chase (ABJ) to improve health care experiences and costs through transforming health care delivery and financing. In that role, Dr. Safran was a member of the executive leadership team and responsible for the company's data strategy, for guiding the development of a robust analytics infrastructure, and for applying data, analytics, and measurement to optimize the venture's success. Prior to her position at Haven, Dr. Safran was Chief Performance Measurement and Improvement Officer at Blue Cross Blue Shield of Massachusetts (BCBSMA). As an architect of the BCBSMA Alternative Quality Contract (AQC) and the leader responsible for its unique use of behavioral economics and payer-provider collaboration to reduce cost while improving quality, Dr. Safran is widely recognized as having contributed to the national push toward value-based payment. Prior to joining BCBSMA, she led a research institute at Tufts University School of Medicine dedicated to developing patient-reported measures of health and health care quality. She remains on the faculty at Tufts and serves on a number of state and national advisory bodies related to health care quality and affordability. Since 2017, Dr. Safran has served as a Commissioner on the Medicare Payment Advisory Commission (MedPAC). She earned her Master and Doctor of Science degrees from the Harvard School of Public Health.